The First Monthly Journal on Insurance in India in service since 1981

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THE INSURANCE TIMES

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In this issue

"Gold jewellery is an integral part of our country's culture and hence we have curated this product specifically for financially shielding customers of Muthoot Finance."

Tapan Singhel
MD & CEO
Bajaj Allianz General Insurance

"Medical costs keep rising each year due to annual inflationary pressures. The ongoing pandemic has only exacerbated the situation. Moreover, there are certain consumables and healthcare items that may be relevant, but are typically excluded by insurance policies."

Anuj Gulati
MD & CEO
Religare Health Insurance

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Editor-in-Chief's Desk

Ram Gopal Agarwala
B.Com, LLB, FCA.

Risk Management awareness is growing at a rapid pace in India and overseas also. Covid 19 has accelerated the pace of adoption in companies at various levels. Top Management and the Boards are also becoming more aware to implement Risk Management strategy as a part of Corporate Governance. Off late regulators have also recognized the need of CRO in companies and issuing mandate in this regard.

Risk Management Association of India (RMAI) promoted by 'The Insurance Times' group is actively engaged in promoting risk management culture in India through regular webinars, training initiatives and awareness programmes. The 30 hours course launched by RMAI has also received good response from various industries including insurance sector. More people are invited to join the association and promote the cause of Risk Management.

West Bengal Govt. has introduced health scheme with 5 lac cover for app. 10 crores people in the State. This scheme has been launched in lieu of Central Govts. Health scheme 'Ayushman Bharat' all over the country.

Automobile Sales have been recovered since October, 2020 which will boost the Insurance sector also as Motor Insurance is one of the leading segment in terms of business. Covid 19 had severely impacted the motor insurance business.

Insurance Industry is now recovering fast with the impact of Covid 19. Since the vaccine may be launched any time now, hopefully the industry will recover soon.

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General Insurance News

PSU insurers asked to reduce avoidable expenses

Finance Ministry has asked 3 PSU General insurers, National Insurance, Oriental Insurance and United India Insurance, to rationalise branches and cut down avoidable expenses to improve their financial health.

The ministry has asked these companies to expand their business through digital medium. They've also been asked to cut the flab by rationalising branches and rein in other avoidable expenses like guest houses, etc,

During the current year the Ministry decided to halt the merger process of three state-owned general insurance companies due to their weak financial positions. Instead, the government approved fund infusion of Rs 12,450 crore to meet regulatory parameters.

As part of capital infusion exercise, the government also approved raising authorised share capital of National Insurance Company Ltd (NICL) to Rs 7,500 crore and that of United India Insurance Company Ltd (UIIC) and Oriental Insurance Company Ltd (OICL) to Rs 5,000 crore each.

The Rs 12,450 crore capital infusion approved by the Cabinet in July includes Rs 2,500 crore provided to these companies during 2019-20. During this year, the government infused Rs 3,475 crore, while announcing infusion of the balance Rs 6,475 crore in one or more tranches.

The government in Budget 2020-21 had made a provision of Rs 6,950 crore for capital infusion in these three insurance companies to maintain the requisite minimum solvency ratio.

NICL, with a combined ratio of 160.8 per cent and underwriting losses of Rs 5,759 crore, has suffered losses of Rs 4,108 crore, while OICL (141 per cent, Rs 4,197 crore) and UIIC (132 per cent, Rs 4,487 crore) have been hit with losses of Rs 1,524 crore and Rs 1,486 crore, respectively in 2019-20. However, New India Assurance, the only exception out of the four public sector general insurers, posted a profit of Rs 1,418 crore in 2019-20.

Underwriting losses of Insurance Industry rise to Rs 22,859 crore

The total underwriting losses of the insurance industry have surged by 4.4 per cent to Rs 22,859 crore in 2019-20, compared to the previous financial year, according to statistics compiled by General Insurance Council.

While New India Assurance contributed the highest net profit of Rs 1,418 crore, the sector - comprising 32 players - has been saddled with total losses of Rs 1,402 crore in FY2019-20.

The industry had made a net profit of Rs 683 crore in fiscal 2018-19 as compared to a net profit of Rs 6,909 crore in 2017-18. The three PSU general insurers, with their large underwriting losses of Rs 14,443 crore, together have been responsible for the overall losses of over Rs 7,118 crore in FY 2019-20.

NIC, with a combined ratio of 160.8 per cent and underwriting losses of Rs 5,759 crore, has suffered losses of Rs 4,108 crore, while OIC (141 per cent, Rs 4,197 crore) and UII (132 per cent, Rs 4,487 crore) have been hit with losses of Rs 1,524 crore and Rs 1,486 crore, respectively, in 2019-20.

Out of 20 private sector general insurers excluding the stand-alone health insurers, 11 players, led by ICICI Lombard General Insurance (with a net profit of Rs 1,194 crore) have succeeded in ending the year with some profitability, while out of six exclusive health insurers only two have made net profit during 2019-20.

Acko General Insurance has witnessed the highest combined ratio (CR) of almost 210 per cent in the industry. It has

been followed by other newcomers like Edelweiss (CR of 193 per cent) and Sachin Bansal-owned Navi General Insurance (CR 165 per cent). Shriram General Insurance, with 91 per cent, SBI General Insurance (93.5 per cent), Universal Sompo (96.5 per cent), Care Insurance (98.4 per cent) StarHealth Insurance (93 per cent) have earned the distinction of having low combined ratio in the industry.

There are very few companies (excluding Care) which have seen underwriting profits in FY 2019-20.

The top three private sector general insurers, ICICI Lombard General Insurance (CR of 100.4 per cent and underwriting losses Rs 105.16 crore), Bajaj Allianz General Insurance (100.8 per cent, Rs 10.90 crore) and HDFC Ergo General Insurance (102.60 per cent, Rs 177 crore) have seen negative CRs and underwriting losses in 2019-20.

General Insurance Corporation of India announces appointment of directors

General Insurance Corporation of India announced the appointment of Anjan Dey, General Manager, New India Assurance Company and Deepak Prasad, General Manager, General Insurance Corporation of India, as 'Director' of the Corporation for a period of three years from the date of assumption of office, or up to the date of superannuation, or until further orders, whichever is the earliest.

Muthoot Finance launches jewellery insurance in partnership with Bajaj Allianz general insurance

Muthoot Finance, has partenered Bajaj Allianz General Insurance, to provide insurance on gold jewellery. The new product known as 'Muthoot Gold Shield' is the gold jewellery insurance scheme launched by Muthoot Finance for its customers. The policy provides insurance coverage for gold jewellery of individual customers. This product is exclusively designed to provide insurance coverage of gold jewellery articles for customers of the company at the time of closure of the gold loan and release of gold ornaments. It is offered as a loyalty product.

This policy covers burglary, robbery, theft from insured person's home, loss-in-transit and 13 other disasters including natural calamities. No documentation is required for this policy and it can be generated in less than 2 minutes.

"Muthoot Finance as a company has always believed in the philosophy of helping people and giving back to society. Going by the initial overwhelming response received for this insurance policy, it has been widely accepted by the customers of the Company. As part of our ongoing customer loyalty programme and social commitment, we are providing customers insurance coverage with an objective to build confidence and help move ahead in life without any fear," said George Alexander Muthoot, Managing Director, Muthoot Finance.

Tapan Singhel, MD & CEO, Bajaj Allianz General Insurance said, "At Bajaj Allianz General Insurance, our endeavour has always been to offer products to ensure that citizens are safeguarded against exigencies. Gold jewellery is an integral part of our country's culture and hence we have curated this product specifically for financially shielding customers of Muthoot Finance in case of any unforeseen events, thus making them worry-free about their jewellery."

ICICI Lombard gets in-principle approval from IRDAI approval to acquire Bharti AXA General Insurance

IRDAI has approved in-principle acquisition of General Insurance business of Bharti AXA General Insurance Company Limited (Bharti AXA) by ICICI Lombard General Insurance Company Limited, the company said in a statement.

Earlier, Competition Commission of India (CCI), BSE Limited and National Stock Exchange of India Limited approved the proposed acquisition.

"Upon closing of the proposed transaction, the consolidated entity will have a market share of 8.7% on proforma basis in the non-life business," ICICI Lombard said in a statement. The proposed transaction is expected to result in value creation for all stakeholders through meaningful revenue and operational synergies, it added.

The policyholders should benefit from an enhanced product suite and deeper customer connect touch points, said India's largest private non-life insurer.

Pursuant to the proposed combination, the entire general insurance business of Bharti AXA would be transferred by way of a demerger to ICICI Lombard in consideration of issuance of shares by ICICI Lombard to Bharti AXA.

Based on the share exchange ratio recommended by independent valuers, shareholders of Bharti AXA will receive two shares of ICICI Lombard for every 115 shares of Bharti AXA. At present, promoter ICICI Bank Ltd holds is 51.89% stake in ICICI Lombard, while the rest is with the public. After the proposed deal, promoter stake will come down to 48.11%.

As a part of the deal, shareholders of

the demerged company i.e. Bharti and AXA will be allotted equity shares of the combined entity of Rs. 10 each with Bharti shareholders receiving 18.23 million shares and AXA receiving 17.52 million shares.

At present, Bharti Enterprises owns 51% in Bharti AXA General, while its France-based JV partner AXA has 49%.

ICICI Lombard is a listed insurance firm, and Bharti and AXA will be public shareholders in the combined entity after the deal.

The proposed merged non-life insurance company is expected to earn a total annual premium of at least Rs. 16,447 crore on a combined basis with market share of around 8.7%, said the two companies in a joint media release.

"This is a landmark step in the journey of ICICI Lombard and we are confident that this transaction would be value accretive for our shareholders. We are excited by the capabilities and strengths that Bharti AXA will add to our franchise," Bhargav Dasgupta, MD & CEO of ICICI Lombard General Insurance said earlier.

Non-life insurance premium falls to Rs. 15,855 crore in October

General insurers reported gross direct premium of Rs 15,855.11 crore in October, down 0.42% year-on-year. However, motor insurance, which was going through a challenging period in the last few months due to the fall in new vehicles sales, saw premiums pick up in October. The pace of the growth in health insurance slowed due to the fall in group health premiums.

Data from Kotak Institutional Equities show that gross direct premium for motor insurance was Rs 7,183.5 crore in October, compared with Rs 6,954.1 crore in the same month last year, a growth of 3%. Motor insurance, which has two segments - motor own damage (OD) and motor third party (TP), also saw growth in October.

Gross direct premium for motor TP was Rs 4,306.4 crore in October, up 4% compared with Rs 4,139.4 crore in October last year. Premiums for motor OD went up by 2% to Rs 2,877 crore in the month under review.

"Robust festive demand and a gradual rise in freight volumes and utilization rates supported premiums. Motor premiums have gradually improved from trough levels observed in April and May and will likely improve further," said the Kotak report.

Health insurance also saw surge in premiums in October. Gross direct premiums for health insurance stood at Rs 4,074.8 crore, against Rs 3,840.6 crore in the year-ago period, growing by 6%. Retail health saw surge in premiums by 30% to Rs 1,982.6 crore. In the last few months, the pace of growth in retail health has slowed down, market players said.

"A slowdown in growth in retail health was likely an interplay of slowdown in daily new Covid cases in India and lower volumes during the festive season. Standalone health insurers reported a 32% Y-o-Y increase in health premiums, led by a 43% Y-o-Y increase in the retail health business," said the report from Kotak Institutional Equities.

Farmers in Maharashtra opt out of rabi crop cover

Farmers across 10 districts of Maharashtra may not be able to avail crop insurance under the Pradhan Mantri Fasal Bima Yojana (PMFBY) this rabi season, as none of the insurance companies have filed bids to implement the scheme in these areas.

Work to implement both weather-based insurance as well as PMFBY for the 2019-20 rabi season has been delayed due to lack of bids, said senior officials of the state Agriculture department. The first few tenders failed to get the required number of bids and they had to be refloated. Heavy underwriting losses and political interference are the main reasons the scheme has become nonviable, said sources in insurance companies.

The state Agriculture department has divided the 32 rabi districts of the state in six clusters and invited tenders for the implementation of PMFBY in all of them. The first tender was floated on September 9 but failed to get the required number of bids for each cluster. In the second tender process, no bids were received for 15 districts, and the tender had to be floated for these clusters again in November. However, 10 districts, including Beed and Solapur, have not received any bids for implementation of the scheme.

The PMFBY is a flagship programme of the central government, under which both the state and central governments pay most of the premium, while the farmer has to pay only 1.5-2 per cent of it. The low premium rates and assured compensation in case of crop loss has prompted farmers in Maharahastra to participate in the scheme in large numbers.

For the financial year 2018-19 , 1.39 crore farmers had opted for the scheme and the total premium collected was Rs 4,778.3 crore. Due to the drought last year, the companies had paid out Rs 3,730.52 crore to 54.46 lakh farmers. ❑

IRDAI News

IRDAI mulls basic standard policy for cyber attacks

IRDAI has formed a working group, to examine the need for standard cyber liability insurance products.

Observing that cyber attacks are on the rise with a number of high-profile data breaches amid the Covid-19 pandemic, IRDAI said cyber security is the "most important need" for all sectors today to address the numerous risks posed by cyber attacks.

The general liability policies do not cover cyber risks, and cyber cover products currently available are highly customised for clients.

"Hence, it is felt that a basic standard product structure is required to provide insurance cover for individuals and establishments to manage cyber risks," IRDAI said in a circular.

The panel will study various statutory provisions on information and cyber security to evaluate critical issues involving the legal aspects of transactions in cyberspace. It will also examine the various types of incidents involving cybersecurity in the recent past and possible insurance coverage strategies for those, and the cyber liability insurance covers available in the Indian market and in other developed jurisdictions. The working group will submit its report within two months.

IRDAI's plan to prohibit use of critical illness policy as collateral for loan may affect nonlife industry

IRDAI is exploring at prohibiting the use of critical illness policies as collateral against housing or vehicle loans.

It's a common practice to have a life insurance or a critical illness policy as a collateral for securing a housing or a vehicle loan from various housing finance companies (HFCs) and non-banking finance companies (NBFCs). The insurance policy acts as a security for the lender as the claims from the policy can be used for repayment of the loan installments in case the policy holder loses his life.

Critical illness policies are issued by general insurance companies and they pay the insured individual a lump sum amount if diagnosed with any of the specific illnesses on a predetermined list. Any move from IRDAI to prohibit use of critical illness policies as collateral for securing loans may be negative for the general insurance companies selling these policies as it may impact their sales.

On the other hand, the move may be positive for life insurance companies as the policies sold by them will continue to have the advantage of being able to act a collateral for securing housing or vehicle loans.

It's this reason why the General Insurance Council (GIC) has expressed its reservation on the regulators move. According to letter written by GIC, critical illness covers are taken by people either to meet the treatment costs or to manage the life style even after diagnosis of a critical illness.

IRDAI notifies Minimum Information for Insurers, Intermediaries and Insurance Intermediaries

On November 23, 2020, the IRDAI has notified the IRDAI (Minimum Information Required for Investigation and Inspection) Regulations, 2020. The Notification will come into force from May 24, 2021.

The objective of the Notification is to specify the minimum information required to be maintained by insurer, intermediary or insurance intermediary, so as to enable the investigating officer to discharge its functions under Section 33 of the Act.

Section 33(1) of the Act empowers IRDAI, if it considers expedient to do so, to direct an investigating officer to investigate the affairs of any insurer or intermediary or insurance intermediary and to submit its report on the investigation made.

Section 33(2) of the Act empowers the investigating officer to cause an inspection to be made of the books of account of any insurer or intermediary or insurance intermediary. Section 33(3) of the Act specifies that it shall be the duty of the "manager", "managing director" and "other officer" of the insurer including a service provider, contractor of an insurer where services are outsourced by the insurer, or intermediary or insurance intermediary, to furnish all such "books of account", "registers", "other documents" and the "database" in its custody, and all such information, as may be sought by the investigating officer.

The investigating officer shall make a report of the investigation and submit the same to the IRDAI. Upon receipt of the report from the investigating officer, the IRDAI, after giving opportunity to give representation, may order in writing: • Require the insurer to take action in respect of any matter arising out of the inspection report; • Cancel the registration of insurer or intermediary or insurance intermediary, as the case maybe; and • Issue direction for winding up the insurer or intermediary or insurance intermediary, as the case maybe.

For the purposes of Section 33 of the Act, the expression "insurer" includes, in the case of an insurer incorporated in India: • all its subsidiaries formed for the purpose of carrying on the business of insurance exclusively outside India; and • all its branches whether situated in India or outside India.

The Notification defines 'Minimum Information' to mean the information specified under the Notification that insurers or intermediaries or insurance intermediaries are required to maintain.

The Notification is divided into 3 (three) parts: • Part I stipulates the provisions that are applicable to all insurers; • Part II stipulates the provisions applicable to the intermediaries and insurance intermediaries; and • Part III stipulates the general provisions applicable to the insurers, intermediaries and insurance intermediaries. ❑

Care Health Insurance launches triple-advantage Care Shield

Care Health Insurance has launched a new product, Care Shield. The product takes into account rising inflation, coverage of certain medical expenses as well as safeguarding the No Claim Bonus (NCB) benefit from lapsing in case of moderate claims of up to 25 per cent of the sum insured. Anuj Gulati, Founding Managing Director, and CEO said, "Medical costs keep rising each year due to annual inflationary pressures. The ongoing pandemic has only exacerbated the situation. Moreover, there are certain consumables and healthcare items that may be relevant, but are typically excluded by insurance policies." He adds, "The third factor for policyholders is that their No Claim Bonus benefit could lapse in case of even small claims. Care Shield is an innovative solution that protects our customers from the aforementioned concerns."

Among some of the highlighted benefits of the product, the company says it also takes into account the rising treatment costs due to inflation, which impacts the ability of patients to afford medical care in the future. Therefore, policyholders buy new policies or increase their existing policy sum insured for keeping the coverage at par with the higher costs arising from inflation. Once added to a policy, Care Shield increases the sum insured at the time of renewal as per the CPI (Consumer Price Index) inflation rate for the previous policy year declared by the competent government authorities, which ensures the customer's policy sum insured is adequate to meet future treatment expenses.

Another feature of the product is the Claim Shield. While health Insurance policies have a list of 60-plus items such as Belts, Braces, Buds, Crepe Bandages, Gloves, Leggings, Masks, Oxygen Mask, Spirometer, Thermometer, Ambulance Equipment and suchlike, which are usually consumed during treatment but generally not covered in the policy, Claim Shield feature provides coverage for these items in case of hospitalization.

With its other feature No Claim Bonus Shield – a reward is given to policyholders during renewal in case No Hospitalization Claim is registered for the policy in the previous year. For instance, if a customer purchased a policy on 01 January 2019 and No Claim was registered during the policy year (between 1st January 2019 to 31 December 2019) then the policy sum insured is hiked by 60 per cent on renewal at no extra cost. This feature also ensures that any low-value claim (<25 per cent of SI) does not lead to an erosion of the accumulated NCB. Ensuring customers' access to quality healthcare, beyond hospitalization, the insurer has included preventive health check-ups, wellness, doctor consultations, diagnostics, and home care.

LIC of India News

LIC launches Atma Nirbhar Agents New Business Digital Application

Life Insurance Corporation of India launched its first Digital Application, "ANANDA", an acronym for Atma Nirbhar Agents New Business Digital Application, recently.

The Digital application is a tool for the on boarding process to get the Life Insurance policy through a Paperless module with the help of the Agent / Intermediary. It is built on paperless KYC process using Aadhaar based e-authentication of the Life Proposed.

ANANDA is a first of its kind in the Indian Life Insurance industry with LIC of India pioneering the process through its in-house IT enabled systems. This tool has been brought out at the right time, to enable and empower the Marketing force of LIC to face the current challenges and propel insurance selling to a higher level. With social distancing being the new normal, prospective customers can avail the facility of taking a New Life Insurance Policy in the comfort of their homes/ offices without having to meet the Agent / Intermediary in person, thereby throwing a new level of opportunity in the purchase of Life Insurance policy.

The event was marked with the release of an e-training video for the Agents, depicting the salient features of the application and the process from introduction to completion of a Life Insurance policy.

The launch had generated tremendous enthusiasm among the Marketing Officials and Intermediaries of LIC of India. The first Life Insurance policy under the Paperless Digital application was issued by the Chairman which was followed by issue of New policies across the Zones of the Corporation.

Chairman of LIC of India said that ANANDA will mark a new chapter in realising the Dreams of its Marketing Intermediaries to use Digital Applications as a Marketing instrument.

The launch was done by M R Kumar, Chairman, LIC of India through Video Conferencing, in the presence of the Managing Directors, T C Suseel Kumar, Mukesh Kumar Gupta, Raj Kumar and other Senior Officials of the Corporation.

Ministry floats request for proposal to appoint actuarial firm for LIC's IPO

Central government has floated a request for proposal to appoint an actuarial firm to calculate the embedded value of the life insurance behemoth.

"In view of the recent announcement by the Government of India in the Budget 2020-21, LIC needs to develop an Indian Embedded Value (IEV) reporting framework and calculate IEV of LIC for the necessary disclosures for the proposed IPO of LIC," said the RFP issued by the Department of Investment and Public Asset Management (DIPAM).

It has, accordingly, sought bids from firms to work with the life insurer to develop IEV, in line with the requirements of the relevant Acts and regulations and to provide support during the IPO process.

"The Global Actuarial Firm would be required to work with the appointed Actuaries and Management of LICI to mutually agree on an appropriate methodology to be used in the calculations of IEV and determine IEV that complies with the requirements of Actuarial Practice Standards and Guidance Notes," the RFP said.

According to the document, the Centre is looking to sell a minority stake in LIC. The end date for submitting bids is December 8, and a pre-bid meeting will be held on November 26.

The selected actuarial firm may also be required to interact with different advisors and stakeholders as well as regulators, including IRDAI and SEBI, specify the 'scope' of the data audit to be performed by the auditor, review iterations of the final results, and also provide inputs and review relevant sections of the IPO offer.

Finance Minister Nirmala Sitharaman had outlined plans to list LIC in the Union Budget 2020-21, along with a target of Rs. 2.1-lakh crore for proceeds from disinvestment. The timeline for the listing is still unclear. The government has appointed transactions advisors for the IPO. ❑

Health Insurance News

57% of COVID-19 claim remains unsettled

The data compiled by the General Insurance Council shows that general insurers are yet to settle and payout 57 percent of the COVID-19 claim amount.

According to the data, general insurance companies across India received a total of 5,53,188 policies for claims under COVID-19. Out of this, insurance companies have settled 3,92,718 policies which keep around 29 percent of policies outstanding and pending for settlement.

The number of outstanding policies may not look very big only till one finds out the amount of the pending claims behind these outstanding policies. The data further reveals that general insurers are yet to pay out around Rs 4,776 crore or 57 percent of the total Rs 8,444 crore worth of claims and this is estimated to be the amount behind the 29 percent pending policies waiting to be settled.

If one looks at the top five states as per COVID-19 claims, unsettled policies lie anywhere between 27-34 percent whereas unsettled/pending claims amount is between 56-60 percent.

According to industry sources, there is a widening lag between the unsettled policies and claims amount because of the slow settlement in some large ticket COVID-19 claims.

Insurance companies allege that hospitals have been discriminatingly overcharging patients who have a health insurance cover and hence insurers and looking into the details of these large claims.

General insurance companies have already made provisions for these COVID-19 claims and now the payout will reflect in their cash flows.

Edelweiss Tokio Life Insurance launches 'Covid Shield +

A coronavirus-focused health insurance plan called 'Covid Shield +' was launched by Edelweiss Tokio Life Insurance recently.

It combines a critical illness benefits and a term cover. The plan has a small base of 1.25 times the premium. The plan is activated after a one-time payment of premium and carries 1-year tenure.

It is a single-disease cover that combines critical illness benefits and term cover. For a minimum premium of Rs 5,329, the plan offers critical illness benefits of Rs 10 lakh 24 hours post Intensive Care Unit (ICU) or High-dependency Unit (HDU) hospitalisation after being diagnosed with Covid-19. The CI benefit is 40% of sum insured.

Commenting on the product launch, Subhrajit Mukhopadhyay, Executive Director, Edelweiss Tokio Life Insurance said, "We have always strived to create relevant innovation, in line with the changing customer needs. Through our recent customer interactions, we realised that the threat of financial impact has made this disease even more daunting. People are worried that a Covid-19 diagnosis will disrupt their savings and therefore their long-term aspirations. We want to take away that worry from our customers through Covid Shield+ and let them focus on a healthy recovery instead of their finances."

The enhanced sum insured which can range from Rs 20-25 lakh gets triggered once the insured person is diagnosed with Covid-19.

If the insured person dies of Covid-19 during the policy tenure, the term cover is paid to the family.

"There were several factors that contributed to this product design. While ICU/HDU hospitalisation can be an expensive affair, the peripheral and post-hospitalisation costs for recovery are also significant. There is also a considerable risk of income loss if the bread-

winner does not survive the disease. Some families are already combating worries of job loss and any huge healthcare expense could completely deplete their savings. Covid Shield+ is a comprehensive solution that provides financial protection against any such eventuality," Mukhopadhyay added.

50% claims out of Rs. 8,000-crore Covid claims filed so far have been settled

Insurance companies have settled less than 50 percent of the claims of nearly Rs 8,000 crore raised so far by COVID-19 patients.

Around 5.18 lakh insurance claims worth Rs 7,973 crore have been filed till November 3, of which 3.97 lakh or 77 percent have been settled. The amount settled, however, is only Rs 3,436 crore or 43 percent of the claim.

Around 1.21 lakh claims worth Rs 4,538 crore are pending clearance and 1,337 claims have been so far rejected, it added.

"Difference in claims made and those settled is due to the time lag between reporting of the claim and submission of final bills," MN Sarma, Secretary General of the General Insurance Council told.

He however added that insurance companies are "able to honour claims deemed reasonable and customary", adding that hospitals were "exploiting patients by charging exorbitant rates."

He said if insurance companies are to cover full bill amounts they would have to raise health cover premiums or exclude COVID-19 from policies.

"There is a lack of standardisation in treatment cost and hospitals have either refused to treat patients with cashless policies or demanded upfront payment," S Prakash, Managing Director at Star Health and Allied Insurance said, adding that discussions to solve this are on.

Bengal Govt announces Rs 5 Lakh Cashless Health Insurance for all residents

West Bengal chief minister extended the benefits of the state health insurance programme Swastha Sathi, which offers cashless treatment benefit up to Rs 5 lakh in private hospitals per family, to all the residents of the state. "All Bengali families will now be able to avail this benefit. Anyone who does not have a health insurance can avail it. Treatment in our government hospitals is free in any case.

This card will come handy in about 1,500 enlisted private health facilities. We had earlier planned to bring 7.5 crore people under this scheme but now we extend it to 10 crore people," Mamata said.

The state population was recorded slightly above 9 crore in 2011 and current estimates claim that West Bengal has a population of 10 crore.

"Ayushman Bharat would have covered only 1.5 crore people. We are covering 10 crore people. For Ayushman Bharat, the card-holder too would have required to contribute. Here, the card-holder does not need to contribute," the CM said adding that the scheme will altogether cost the state exchequer Rs 2,000 crore. With a woman in the family as the holder of the card, parents of married women can also avail the benefits of this cashless insurance, she added.

The decision comes amid the BJP's consistent campaign that the state government was depriving the people of the state by not implementing the Ayushman Bharat scheme launched by the government of India.

Digit Insurance introduces one cover for 8 viral diseases including COVID-19 and Dengue

Digit Insurance has introduced its latest offering under Digit's Illness Group Insurance that will protect an individual against hospitalization bills arising out of COVID-19 and 7 Vector-borne diseases like dengue, malaria, filariasis (payable only once in a lifetime), kala azar, chikungunya, Japanese encephalitis and the zika virus. One will be covered for hospitalization expenses if one is diagnosed with and hospitalized solely for any of the specified diseases and even for COVID-19.

Digit's cover for COVID-19 and Vector-borne disease policy also covers pre-hospitalisation expenses for up to 30 days, post-hospitalisation expenses up to 60 days, road ambulance charges (1 per cent of your chosen sum insured, up to Rs 5,000) and a second medical opinion. The product is currently available on Digit's website and offers options of choosing sum insured of Rs 1 lakh, Rs 2 lakh or Rs 3 lakh.

The plan has been launched under Digit's Illness Group product under the Sandbox regulations which encourages insurance companies to launch innovative products.

In its statement, the company states that according to the WHO (World Health Organisation), vector-borne diseases account for 17 per cent of all infectious diseases and leads to 700,000 deaths every year, worldwide. India has a long history of malaria due to both its large population and climatic conditions. 2018 alone saw 429,928 cases of malaria and 96 malaria deaths! Hence, it is important to have an insurance policy that covers these diseases. ❑

Private Life Insurance News

Life insurance premium eligible for reimbursement under LTC cash voucher scheme

The premium paid for insurance policies purchased between October 12, 2020 and March 31, 2021 by central government employees will be eligible for reimbursement under the LTC cash voucher scheme.

On October 12, the government announced the LTC cash voucher scheme under which employees can purchase any goods or services with a GST rate of 12 per cent or above to avail themselves. The payments for such purchases have to be made via digital mode or cheque or demand draft or NEFT/RTGS.

So far, employees had only leave travel concession (LTC) benefits on travels made, or else they had to forgo the amount. The expenditure department said payment of premium for existing insurance policies would not be covered under the LTC cash voucher scheme.

"However, the payment of premium for insurance policies purchased during the period between October 12, 2020, and March 31, 2021, is eligible for reimbursement under the scheme," it said.

Vouchers/ bills for availing the benefit under the scheme has to be submitted on or before March 31, 2021.

On the submission of bills by employees who would superannuate before March, the expenditure department said, "vouchers/ bills should be submitted and settled before the date of superannuation".

Insurance start-up Plum raises $4 million

Sequoia Capital India backed insurance startup Plum has raised ₹4.1 million in a bid to provide group health insurance to small and medium enterprises.

The recent round of funding for the start-up, which was launched in March this year, is led by Sequoia Capital India and Tanglin Venture Partners. Existing investors, including Incubate Fund, also participated in the funding round.

The insurer said that the amount raised would be used to expand in new markets, build distribution channels, hire talent and develop products.

Since launch, the company has seen rapid growth, securing $1 million worth of insurance premium. The platform has more than 200 companies on board.

The funding round is part of the fourth cohort of Sequoia Capital India's Surge initiative where 17 start-ups collectively raised $45.35 million. The initiative provides seed capital allowing start-ups to scale up their operations.

Small businesses find the process of purchasing insurance tedious and costly as they are unable to negotiate group policy pricing with a small employee base. But health insurance has gained awareness following the pandemic.

"The group health insurance market in India is projected to grow to $13.4 billion by 2025 and we will see the rise of innovative insurance products. Plum hopes to provide 700 million people with employer-sponsored insurance," said Abhishek Poddar, co-founder of Plum.

No Income Tax on life insurance policies of 10 or more years, ICAI recommends Central govt

In its Pre-Budget Memoranda - 2021, the Institute of Chartered Accountants of India (ICAI) has recommended the Union government to make all life insurance policies with a policy term of 10 years or more exempt from tax. The Institute has suggested that the tax exemption on life insurance policies should now be provided based on

the policy term and not the premium to sum assured ratio, which is being currently done.

At present, tax exemption under Section 10 (10D) is based on the premium to actual capital sum assured ratio. Because of this, life insurance policies with a higher premium due to age factor, occupational/lifestyle diseases etc. gets treated as taxable. And, policyholders who need insurance cover are denied tax relief due to higher premiums, ICAI noted.

To provide relief to such policyholders, the ICAI has suggested the government that the "tax exemption should not be linked based on premium to sum assured ratio."

Instead, "all LIPs with policy term of 10 years or more should be exempt," ICAI said.

ICAI added that tax exemption based on policy term will help in medium to long term investments.

Currently, any sum received under life insurance policies not exempt under section 10 (10D) are taxable. ICAI says that the deduction of only premium while computing the net income/loss after surrender/withdrawal of policy doesn't take care of inflation resulting in higher taxability.

To solve this issue, ICAI suggests that life insurance policies should be treated as a capital asset falling within the definition of "property" under Section 2(4) of the Income Tax Act.

"Indexation benefit (for premiums paid) will take care of inflationary impact- resulting in parity with other capital assets," the Institute said.

The ICAI has also suggested that insurance companies should be allowed to carry forward and set-off unabsorbed business losses for an indefinite period. Currently, there is a limit of 8 years for carry forward and set off of business losses. ICAI said that this limit is "not sufficient".

Life insurers register 32% increase in new business premium income

Life insurers reported a 32 per cent jump in new business premiums (NBP) in October, helped by healthy growth in single premiums and group non-single premiums. This comes after the industry saw a 16 per cent rise in NBP in the September quarter.

Life insurers, 24 in total, earned NBP of Rs 22,776 crore in October, compared to Rs 17,271.86 crore in the corresponding period last year. In September, NBP was up 26.47 per cent at Rs 25,366.32 crore.

The numbers are in sharp contrast with the decline in business seen by insurers in the initial days of the Covid-19 pandemic. In Q1FY21, NBP had plummeted more than 18 per cent due to the pandemic-induced lockdowns imposed across the country to curb the spread of Covid-19.

LIC led the growth in October, with its NBP up 36 per cent at Rs 15,548 crore, compared to Rs 11,422 crore in the same period last year. The private insurers, on the other hand, saw their NBP grow 23.5 per cent to Rs 7,228 crore, compared to Rs 5,849.71 crore in the year-ago period.

In the first seven months of FY21, NBP has gone up a marginal 3.13 per cent to Rs 1.47 trillion, compared to Rs 1.43 trillion in the corresponding period a year ago. While private insurers' NBP grew almost 6 per cent in the April-October period to Rs 43,937.59 crore, LIC's NBP grew 2.13 per cent to Rs 1.03 trillion.

The industry bounced back as insurers, especially the large ones, managed to digitise their selling process, capitalising on the increased awareness of insurance among consumers amid a pandemic. Also, the surge in demand for term products, as well as guaranteed products, helped in recovery.

Experts see the demand increasing as life insurance is becoming a "pull product rather than a push product". They expect Q3 to be better than Q1 and as good as Q2, if not better.

Bharti AXA Life Insurance reports 10% rise in renewal premium

Bharti AXA Life Insurance said it has registered a 10 percent increase in renewal premium at Rs 594 crore in the first half of the current fiscal year.

The company's renewal premium stood at Rs 541 crore in April-September of fiscal year 2019-20, Bharti AXA Life Insurance said in a release.

The COVID-19 crisis and subsequent disruptions hit the company's new business premium income, which stood at Rs 318 crore in the half-year ended September 30, 2020 as compared with Rs 415 crore in the same period during 2019-20, it said.

Annualized new business premium was at Rs 207 crore in the first six months of financial year 2020-21. Total premium income fell moderately to Rs 912 crore in April-September period of this fiscal from Rs 956 crore in the first six months of previous financial year, the insurer said.

The ongoing pandemic notwithstanding, the company recorded a surge of 25 per cent in its assets under management at Rs 7,987 crore in the first half of 2020-21 as against Rs 6,404 crore in the corresponding period of the last fiscal, it said.

"The spread of COVID-19 pandemic has impacted the economy and the business sentiment in the short-term.

Despite the challenging macro-environment affecting the new business adversely, we registered steady performance on many parameters and achieved double-digit growth in the renewal premium collection in the first six months of the current financial year," Bharti AXA Life Insurance Managing Director and Chief Executive Officer Parag Raja said.

The company's assets under management saw a strong growth amid the slowdown triggered by the COVID uncertainty, he added. With economic activities picking up after easing of restrictions, the company is confident about the business recovery and growth in the second half of this fiscal, Raja said. Bharti AXA Life Insurance said it plans to expand its distribution footprints across the country and strengthen its multi-channel architecture. Currently, it has 261 branches and 36,526 advisors.

The company is focusing on digital innovation within its distribution bandwidth to meet the rising bar of higher service standards and growing customer expectations, the release said. Bharti AXA Life maintained business momentum amid uncertainties by embracing new digital tools and capabilities and enhanced experiences of customers, employees, partners and other stakeholders, it added.

Max Life Insurance hires 2,000 executives via digital medium during COVID-19

Max Life Insurance said it has hired over 2,000 executives during the first half of this fiscal in midst of the COVID-19 pandemic.

By efficiently digitizing its recruitment and onboarding process, the life insurer has been able to deliver a seamless employee hiring and onboarding experience in a predominantly remote work set-up, the insurer said in a statement. With the addition, the total workforce strength rose to about 15,000.

Hiring was done across diverse verticals such as agency, bancassurance, and internal operations, it said. In the last six months, Max Life has also proactively engaged with more than 500 candidates digitally to create a talent pool for future hiring, it added.

Reliance Nippon Life Insurance leases 40,000 sq ft at Adani Inspire in BKC

Reliance Nippon Life Insurance has taken a 40,000 sq ft space on a five-year lease at an Adani Realty project in the BKC business district to house its corporate headquarters, officials said.

"RNLI has signed up to have 40,000 sq ft in Bandra Kurla Complex's (BKC) Adani Inspire for five years," a source said.

"Corporate office relocations are a matter of long term commitment and the recovered business sentiment regarding the value of life insurance product gives us the confidence to make this decision. BKC is a prominent and centrally-located business district," Vohra told.

RNLI will be moving to the space from Reliance Centre in nearby Santacruz, whose possession has been taken over by Yes Bank for non-payment of loans.

Life Insurance: Premium collections of private life insurers' up 15%

Life insurers reported 14% year-on-year (y-o-y) growth in individual annualised premium equivalent (APE) in October 2020 compared to 4% y-o-y in September 2020 and 6-40% y-o-y decline over April-August 2020. Gradual revival in unit-linked insurance plans (ULIPs), increase in sales through agency channels and strong traction in non-par savings segments are likely drivers.

Individual APE increased 14% y-o-y in October 2020 for private players while group APE was up 24% y-o-y, translating to 15% y-o-y growth in overall APE. On a sequential basis, this was up from 4% y-o-y in September 2020 from 7% y-o-y decline over June-August 2020.

Even as protection growth has likely slowed down from peak levels (ratio of individual non-single sum assured to individual non-single premium was broadly flat y-o-y at 31X; 41X for 7MFY21 compared to 32X in 7MFY20), pick-up in ULIPs, traction in non-par savings and gradual revival in group credit business (11% y-o-y growth in group sum assured against 37% y-o-y decline in 7MFY21 and 30% y-o-y decline in September 2020) led to strong growth in overall APE. LIC's individual APE was up 6% y-o-y; overall APE was up 7% y-o-y on the back of 9% y-o-y growth in the group business.

HDFC Life reported 45% y-o-y increase in individual APE in October 2020 (up 43% y-o-y in September 2020); individual sum assured was up 6% y-o-y (up 4% y-o-y in September 2020 and 11% yoy in 7MFY21) in October 2020. Overall APE was up 47% (up 45% y-o-y in September 2020) on the back of strong growth in the group business (group APE was up 60% y-o-y compared to 55% in September 2020); credit life has likely picked up. Growth in individual business was likely driven by strong traction in the flagship traditional businesses. HDFC Life's strategy to toggle between product classes has helped it deliver better than industry.

ICICI Prudential Life reported 22% y-o-

y decline in individual APE in October 2020 (down 24% y-o-y in September 2020). It continues to report lower-than-industry growth owing to pressure on ULIPs and likely slowdown at ICICI Bank. Individual sum assured was down 3% y-o-y reflecting moderation in protection product. While ULIPs have likely picked up sequentially, it remains weak on a y-o-y basis.

SBI Life's individual APE was up 14% y-o-y in October 2020 (decline of 4-14% y-o-y over July-August 2020). Overall APE was up 13% y-o-y. Individual sum assured was up 10% y-o-y while group sum assured was up 45% y-o-y; credit life has likely held on well.

Max Life' individual APE was up 49% y-o-y while individual sum assured was up 25% y-o-y. Traction in the non-par savings business continued to support growth in Q2FY21. Max Life has fared better than most peers during the pandemic. Group APE was up 35% y-o-y while group sum assured increased 1.1X y-o-y; credit life has likely revived.

Genesis BCW wins national PR mandate for IndiaFirst Life Insurance

Genesis BCW has been appointed as agency on record for IndiaFirst Life Insurance Company Ltd (IndiaFirst Life), following a multi-agency pitch.

Genesis BCW will strengthen IndiaFirst Life's core brand value of being a trusted business leader in the life insurance and pensions sector, leveraging through an integrated communications approach combining strategic counselling and communication, media advocacy, crisis preparedness and driving thought leadership in the banking, financial services and insurance (BFSI) space.

"We are delighted to announce Genesis BCW as our communications partner as we take our #CustomerFirst philosophy ahead," said IndiaFirst Life Insurance Company Ltd deputy CEO Rushabh Gandhi. "By leveraging Genesis BCW's expertise and long-standing experience, we aim to enhance IndiaFirst Life's brand visibility and connect among all our stakeholders. We are confident this partnership will help us communicate our purpose as a brand and build on our vision of securing lives and creating value."

"This is an exciting opportunity for us to support one of the youngest and fastest growing life insurance companies in the country in its communications journey," said Genesis BCW CEO Deepshikha Dharmaraj. "We are living in a world of heightened ambiguity, and IndiaFirst Life aims to give their customers assurance in these challenging times. We look forward to spreading their message of #LifeIs Full Of Certainties and help them build strong relationships with their stakeholders based on trust and values."

Max Life Insurance launches second edition of its insurtech accelerator program

After a successful first edition of Max Life Innovation Labs in 2019, Max Life Insurance Company Ltd. announced the launch of the second edition of its flagship insurtech accelerator program. With the launch of the second edition of Max Life Innovation Labs, the life insurer is inviting technology startups to build smart fintech and insurtech solutions for specific business challenges.

Conceptualised in partnership with Invest India - the national investment promotion & facilitation agency of India, which will host the programme on the Startup India Hub, the program will provide startups the opportunity to access knowledge, infrastructure, and support from Max Life to transform business processes through technology. Max Life plans to select startups to co-develop solutions in the areas of artificial intelligence/machine learning, smart underwriting, blockchain, health & wellness, intelligent data acquisition & advanced data analytics.

Saral set to heat up term insurance mkt

The term protection market in the life insurance industry is set to heat up with insurers readying to launch Saral — a standard term policy that has been designed by the regulator, where insurers are expected to compete on price.

In October, the Insurance Regulatory and Development Authority of India (Irdai) directed all life insurers to start selling from January 1, 2021 the Saral Jeevan Bima — a cover with standard wording for sum insured ranging from Rs 5 lakh to Rs 25 lakh. Although insurers have been wary of selling lower value term covers, the rise in demand for term cover during the pandemic has shifted focus to protection.

According to ICICI Prudential Life Insurance MD & CEO N S Kannan, there has been a 70% increase in online search for 'term insurance' during the pandemic. "Retail sum insured has gone up by 5-6% during this period. Sum insured is growing ahead of GDP, which is good news for industry," said Kannan. At the same time, claims have been less than what was expected during the pandemic. "We had created an additional reserve, which did not get used up. This is a bit sad as it is an indication that insurance penetration is low," he said.

Besides ICICI Prudential, Life Insurance Corporation and other private companies are working on the product. ❑

International News

Aon launches lease with telematics-based pay-per-use insurance

Global insurance broker Aon has launched a personal car leasing product that includes pay-on-use insurance, giving customers the advantage of saving money when they are not driving.

The company will adjust its insurance premiums according to how far a car is driven, using a telematics system to track cars.

Called Flee, the product has been designed for the employees of Aon's business clients, and tailored to meet the needs of the 'new normal' as workers prefer to avoid public transport and mix working between office and home.

Launching Flee in Italy, Aon said the cars will be supplied by ALD Automotive Italia on 36, 48 or 60-month contracts, including maintenance, road tax and breakdown assistance, for fixed monthly rentals.

But drivers will have the option of a flexible premium for fully comprehensive insurance cover. The premium is based on a fixed cost per kilometre multiplied by the total distance driven in a month. There is also a small variable monthly fee for extra Flee services, such as booking a service and maintenance and for claims assistance in the event of an accident. This fixed figure is also multiplied by kilometres driven to calculate the total monthly charge.

Flee will monitor mileage via the telematics system - if the car hasn't moved, the variable insurance element of the rental is zero.

"If, on the other hand, you travel, the variable part will be the value of the kilometres traveled for the cost per kilometre indicated," said Aon. "If you travel a little more, don't worry because you never pay more than the maximum amount indicated in your quote."

Gabriele Ratti, director of Aon Mobility Solutions, said: "We started from an innovative insurance product with high added value and, collaborating with sector leading partners, we have created an offer that goes beyond insurance, providing the end customer with an integrated mobility service."

ALD Automotive Italia, which has a fleet of almost 190,000 vehicles, said flexibility was high on the agenda of private drivers, freelancers and companies as they deal with business uncertainty. The leasing company added that Flee opened: "a new frontier of pay-per-use."

Targa Telematics will provide the vehicle tracking technology that captures the data for the pay-per-use insurance. The same technology will also support safer, greener driving behaviours by providing drivers with a dashboard of their performance behind the wheel, including fuel consumption and incidents of harsh acceleration, cornering and braking, as well as exceeding speed limits.

Alberto Falcione, Targa Telematics vice president of sales, said: "Telematics and data analysis and management are crucial to implement truly innovative solutions able to effectively respond to changing customer needs. We provided Aon with our expertise, our automotive-specific IoT platform and a wide choice of software modules and microservices, with the aim of helping them implement a new mobility solution."

General insurance business in Malaysia to contract by 2.2% in 2020 due to COVID-19

The Malaysian general insurance industry is expected to contract by 2.2% in 2020, primarily due to weak consumer demand and suspension of economic activity due to the lockdown restrictions in the aftermath of COVID-19 pandemic, according to GlobalData, a leading data and analytics company.

GlobalData has revised Malaysia's general insurance forecast in the aftermath of COVID-19 outbreak. As per

the latest data, Malaysia's general insurance business is expected to grow at a compound annual growth rate (CAGR) of 2.4% during 2019-2024 compared to the earlier forecast growth of 4.9%.

Sangharsan Biswas, Insurance Analyst at GlobalData, comments: "Malaysian economy is projected to contract by 4.9% in 2020, which will adversely impact consumer spending. The recent floods in the country will further dampen economic growth, resulting in lower premiums for general insurers."

The slowdown is most evident in the motor insurance business, which accounted for 48.3% of the total general insurance premium in 2019. According to the Malaysian Automotive Association (MAA), new vehicle sales registered a decline of 41.1% during January to June 2020, compared to the same period in 2019, due to lockdown restrictions and stalled production.

Despite government efforts to improve automobile sales through sales tax exemptions, the uncertainty related to economic recovery and weak domestic demand is expected to impact new premium collections for motor insurers.

Similar decline is observed in property insurance, which was already facing stagnancy. As per National Property Information Centre (NAPIC), property sales by value recorded a 31.5% decline in the first half of 2020. Decline in construction activity and negative sentiment for purchasing residential property due to the current economic scenario has impacted the growth of property insurance business.

Bank Negara Malaysia (BNM) is exploring options to improve the business potential of the country's insurance business. BNM is introducing measures such as detariffication of fire and motor insurance business lines. It is also promoting digitization to enhance customer interaction and improve operational practices of insurers.

Mr Biswas concludes: "Despite the regulatory push, the recent surge in infection rate across the country is expected to further dampen growth prospects. Weak export demand and uncertain economic scenario are expected to limit the short-term growth potential of the general insurance business."

MS&AD to use Tractable's AI across Japan to accelerate recovery from auto accidents

MS&AD, one of the world's largest property and casualty insurers*, is to use AI to accelerate how it processes auto claims, speeding up recovery for its policyholders.

The AI solutions, created by technology company Tractable, use computer vision to analyse photos of car damage - making sense of it as a human would, in near-real time.

MS&AD will deploy the AI across both of its subsidiaries, Mitsui Sumitomo Insurance (MSI) and Aioi Nissay Dowa Insurance (ADI), where it will be used across hundreds of thousands of auto claims a year, accelerating how quickly each is processed by as much as two weeks per claim.

These deployments signify wide-scale, mass adoption of AI across MS&AD's operations, and mean that vehicles will be returned to policyholders in Japan more quickly than previously possible.

Keiji Goto, GM for Technical Support, Claims Division at MSI, said: "By applying Tractable's market-leading AI, we will be able to solve long-standing challenges to the claims cycle, such as how to accelerate supervisor approval of work carried out by our appraisers. We're excited by the standard of the AI and its capacity to help us make better, faster decisions for our customers."

Tadashi Yamanaka, Staff GM, Claims Administration Department at ADI, said: "Tractable's AI will change how insurance claims are processed. As a result, drivers across Japan will see a faster response time to their claims, proving ADI's commitment to delivering the best possible service."

As well as Japan, MS&AD operates across over 40 countries, and its core units, MSI and ADI, have extensive foreign auto operations in Asia, the Americas and Europe. MS&AD is the fifth-largest P&C insurer globally.**

Alex Dalyac, co-founder and CEO, Tractable, said: "It's inspiring that one of the world's leading insurers is making a bold move into the future with Tractable. By deploying our AI across Japan, MS&AD will enable its policyholders to benefit immediately from cutting-edge technology that shortens the claims cycle by weeks."

In auto insurance claims, time is frequently lost scheduling visual appraisals of the damage, which may occur multiple times throughout the claim. By capturing images with AI and converting them into instant appraisals, Tractable's AI allows the insurer and repairer to move claims forward immediately, accelerating the process by as much as two weeks. For its adjusters, MS&AD believes the advance will save as much as 360,000 hours of time every year.

Tractable's AI has been trained on photos and human repair decisions across millions of historical accidents. Through experience, the AI has learned to understand damage to any passenger vehicle across Europe, Asia and the Americas. The system continually improves as more insurers and repairers benefit from its use.

Tractable's AI has processed over ₹1 billion in auto claims for the world's top insurers, including Ageas UK, Covéa, the largest auto insurer in the French market, and Talanx-Warta, the second-largest auto insurer in Poland. ❑

HEALTH INSURANCE LANDSCAPE: BEFORE & BEYOND 2020

'Pandemic providing more opportunities than challenges in Health Insurance Segment.'

Health overtakes Motor:

Year 2020 will forever be remembered as a decisive, dreadful & most disruptive time in the history. The pandemic is still frightening and cases are rising every day. It is scary and it suggests that we have not yet reached the peak. We are among the top worst hit countries by Covid-19. We have learned to live with this fearful situation and this is now the new normal.

Pandemic is challenging health insurance industry on various fronts at the same time when the Regulator also brought in many revolutionary changes through next phase of standardization reforms to bring uniformity and transparency in health insurance contracts. Standard retail product and standardized exclusions will surely bring trust back. It will change the face health insurance in India and the balance of power will tilt towards the customers.

Set of challenges are evolving the health insurance industry at very fast pace and these changes are driving transformation in health insurance risk landscape. It is true that evolution never stops and that change is the only constant. The pandemic has changed the way people look at health insurance. The COVID-19 crisis continues to have significant impact on insurers even when they triggered on time their 'Business Continuity Plans' in most effective manner and yet when insurers are transiting from respond to recovery phase in their retort to COVID-19.

Pandemic has changed the dynamics of general & health insurers. It has significantly disrupted economic activities in the country resulting in significant business drops thus resulting in shrink in insurance income. Motor segment has been hit worst. It has taken a toll on new premiums as well as renewal premium in Motor Insurance segment in FY 21 due to dipped production and reduced economic activity. Motor Insurance that used to remain the growth navigator at industry level witnessed de-growth of 15.73% in premium volumes till August 2020. This segment which holds the

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leading position with GDPI of Rs 69,208 crore and which contributed 39.21% share in GDPI of Industry in FY20 lost its top position to Health Insurance Segment when its share shrink to 32.28% of GDPI.

Covid-19, on the other hand increased awareness for health insurance and contribution of health insurance in GDPI increased from 27.67% in FY20 to 33.22 up to August 2020. Retail Health Insurance registered a significant growth of 32.88% in this period to achieve overall growth of 12.97% in Health Insurance space. Thanks to newly launched Corona specific health insurance products that contributed a lot for this impressive growth. For the first time seven Standalone Health Insurers (SAHI) prominently generated more health insurance business than 24 general insurers.

While the demand for health insurance has picked up considerably its utilization has also dropped drastically as policyholders avoided elective treatments. Combined effect of both will provide ample opportunities to forward looking insurers to make health vertical an'aatmanirbhar (self-sustaining) profitable vertical.'

Planned surgeries will eventually happen and claims costs could go up. The insurers should keep this factor in mind especially while rating tailor made products that may produce decreased combined ratios for a shorter term. Year 2020 will also be remembered in time zone as a period when Health Insurance occupied the position of top contributing segment in GDPI of General Insurance sector. Health insurance seems amidst an exciting journey.

Table- 1
INDIAN GENERAL INSURANCE MARKET - August 2020

	Motor	Health	Total
August, 2020	22254	22903	68939
Segment share	32.28	33.22	100.00
March,2020	69208	51638	189302
Segment share	36.56	27.28	100.00
March,2019	64523	45532	164559
Segment share	39.21	27.67	100.00

(Source: GI Council segment wise data report)

Protection Gap between ailment and claims:

The protection gap is a difference between insured losses and uninsured losses or economic losses. This term is generally remembered following a catastrophe to recollect that properties and economies with low insurance penetration takes much longer time and require more government support to recover after a natural disaster.

The challenge of under-penetration and protection gap is equally relevant during this pandemic to realize that social and economic cost of being uninsured or underinsured is massive and serious pushing individuals to the vicious trap of poverty. Duration of illness for Covid positive patients is much longer and social distancing and isolation protocol raises the treatment cost exponent. The economic progress and hard earned savings of individuals over decades may get wiped out in meeting uninsured medical expenses out of pocket.

The protection gap as reflected by the level of insurance claims during this pandemic to actual number of corona positive cases expose a serious cause of concern for us. In FICCI conference, Member Non-Life shared vital information that while the number of COVID-19 positive cases in India was more than 27.7 lacs, the insurance claims intimated up to August 18, 2020 were only about 1.25 lacs. In other words 96% of the COVID-19 affected population was not covered by commercial insurers.

This reminds that health insurance penetration is still low in India and those insured are also largely under-insured. This number is proportional and reflect that about 4% of Indian population is covered by commercial insurers. Larger part of covered population is through government health insurance schemes. This protection gap is becoming more pronounced with time when COVID-19 is spreading more to Tier-2 and Tier-3 cities and even to villages as the penetration of health insurance is so minimal to population residing in these locations.

Trends of claim arising from novel COVID-19 has kept its upward momentum in past few months, however, the protection gap has dipped by 1% in past few months after booster sale of COVID-specific health insurance products. A Report suggests that as on 30th September 2020 3.18 lac Covid related claims amounting to Rs 4,880 crore were intimated to the insurers.

On that date India had 62.25 lacs Covid positive cases and so the claimed ratio to ailment improves to 5% from 4% in a month. If the population covered under Ayushman Bharat (PMJAY), CGHS & other schemes is included the percentage of protection gap may improve slightly better but still there

remains a threat of larger portion of the population being pushed to the poverty trap as the pandemic spread is still not contained & controlled.

Ayushman Bharat and several State Schemes converged or not with PM-JAY provides health coverage to more than 13 crore households or to 53% of population base. These schemes also provide coverage for treatment of Corona Virus Disease-19. Despite that such huge protection gap exposes the efforts of universal coverage in this segment. The average cost of treatment for Covid is more than Rs one lac (Table-2) and with co-morbid conditions the length of stay and cost of treatment increases manifold. Pandemic may expose such costs to a very large part of the poor and middle class population and that may lead to a situation worst in its form beyond imagination.

Regulatory effort to make available the Corona specific health insurance products at a very low cost even to people with pre-existing co-morbid conditions is very innovative to bridge this gap. These products have been recognized as felt-need products and have provided a booster shot to the health insurance in India. More than 130 health insurance products were approved by the IRDAI in past few months. This is when the industry saw only 500 odd products in last 20 years. The future will see willing health insurers moving from pure indemnity model to wellness models and also offering disease specific and OPD covers that will sharply reduce the ratio of out of pocket expenses for Indians. Health insurance landscape recognizing preventive model from pure curative model will change the dynamics of practicing health insurance.

Increase in claims arising out of COVID-19 is not going to hurt the insurers much in FY 2021 as these would get balanced by non-utilization of health care for the non-COVID treatments as more and more people are avoiding hospitalization for planned surgeries. People are staying away from hospitals for all kind of elective and optional surgeries from last 6 months in this financial year and this trend is going to remain so till the end of this financial year. A Report of ICICI security suggest that COVID-19 claims may be around Rs 10,500 crore at the end of FY21. This may be less than 18% of total health insurance claims at the end of FY-21. At present COVID-19 claims are approximately 12% of total health insurance claims.

Table -2

General Insurance Companies COVID 19 claims (11 September 2020)

Insurer (Name of Insurer is not disclosed)	Reported Claim			Settled			% of reported claim
	Number	Amount	Average Claim cost	Number	Amount	Average Claim cost	
PSU	38770	6478920907	167111.71	18405	2081459810	113092.08	67.67
SAHI	37500	8618929871	229838.13	29894	2844332611	95147.27	41.40
PSU	36672	3678033949	100295.43	21681	1791003855	82607.07	82.36
PSU	21348	3166456719	148325.68	18405	2081459810	113092.08	76.25
PSU	18489	2861138520	154748.15	12827	1283036630	100026.24	64.64
Pvt Insurer	11386	1157404789	101651.57	6817	665585312	97636.10	96.05
Pvt Insurer	7454	1202374986	161306.01	4174	429660597	102937.37	63.81
SAHI	5225	895459895	171379.88	4562	477097703	104580.82	61.02
Pvt Insurer	4719	567371516	120231.30	2465	256841979	104195.53	86.66
SAHI	3911	718462095	183702.91	3911	405405764	103657.83	56.43
Other Insurers	25864	3799974610	146921.38	10353	578318948	55860.04	38.02
Industry	211338	33144527857	156831.84	133494	12894203019	96590.13	61.59

Gap in Coverage-Indemnity and Medical Expenses in Health Insurance Products:

Health insurance penetration is still low in India and those insured are largely under insured. In India, morbidity protection and coverage gap in insurance products remain high for the fact OPD cover normally is not covered in indemnity products. Further these products limit liability on account of caps, limits of sum insured, co-pay, deductibles and exclusions that

require policyholder to meet certain medical expenses out of his pocket for in-patient medical episodes.

COVID-19 was declared a global pandemic by the WHO on March 11, 2020. Since then the scientific understanding of the virus, medical response to deal with its treatment at care centers and action taken by the Government to provide access to health care and tests, efforts by the Regulator to ensure relevant products providing coverage for its treatment and by Insurers to provide financial protection to reduce out of pocket expenses are fast evolving.

Insurance Regulator remained pro-actively engaged with the insurers to protect the interest of policyholders and to drive out common misconceptions about coverage in existing policies it issued necessary instructions to insurers to clarify and notify them that pandemic claims were covered in existing health insurance policies. IRDAI also issued guidelines to quickly settle the COVID-19 claims against health insurance policies. However, the contractual liability of insurers is governed by insurance contract.

Since the existing health insurance products were not designed to deal with this pandemic and the treatment protocol was unknown, the policyholders were surprised to find that significant share of total care bill was not covered in the policy contract. Apart from it the treatment costs during quarantine at home were also not admitted as liability by the insurers. This increased the share of already high out of pocket expenses much higher on customers.

Personal Protective Equipment (PPE Kit), gloves, sanitization, sterilization, consumables, masks, face shields that are unavoidable to contain the spread of the novel corona virus and which are frequently used in Covid treatments were considered as non-medical items in existing policies and insured patients were not indemnified against cost of such consumables. Insurers maintained that these fall under disallowed expenses so were not payable as per the terms and conditions of health insurance contracts.

Non-transparency in hospital billing pattern at the end of hospitals was also observed when PPE and other consumables were subsumed in room rent by some of the providers. Capping of room rent and proportionate linking of associated medical costs further complicated the reimbursements in such cases. Hospitals maintained that apportionment of PPE kit across patients was not medically advisable as these were not used for treatment of multiple patients.Plasma therapy cost was not considered by certain insurers being an experimental therapy. Expenses related to unproven treatments are excluded in health insurance products.

The average cost of consumables in health insurance claims normally remain less than 10% but considering the nature of illness and its treatment protocol the consumable cost for treating COVID-19 patients was found up to 50% of total cost bill. The virus is highly infectious in nature and it is necessary to contain its severity by use of such consumables which remain single use item for its treatment. Longer stay in hospital and social distancing to contain spread significantly raises the cost of consumables.

Further the terms and conditions of the health insurance policies covered only in-patient care and some of the policies provide cover for domiciliary treatment. Disallowed expenses included nebulization kit, steam inhaler and oxygen cylinder outside hospital, gloves & oxygen mask.

Gap in coverage to such an extent created a situation that even those who were having the health insurance policy remained underinsured for substantial share of treatment cost. Trust went missing and grievance shoot up to maximum. Realizing the evolving needs of policyholders and the gap in actual treatment expenses and indemnified protection available in existing products the Regulator quickly recalibrated the product design to bridge these gaps and prescribed two standardized COVID products w.e.f July 10, 2020.

Single Risk COVID-19 Health Insurance Products:

In wake of pandemic the concern of policyholders was recognized by the Regulator and after careful analysis of treatment protocol and prognosis around COVID-19, though

evolving and emerging every day, the Regulator designed and prescribed Standard COVID-19 specific policies addressing the basic insurance needs after bridging the gaps observed in indemnity based current health insurance contracts.

Corona Kavach is an indemnity product that has to be mandatorily offered by health/general insurers whereas the Corona Rakshak is optional benefit based product. The design of the product is standard with common guidelines across the industry and insurers are allowed only to have price discovery for these standard products based on their actuarial evaluation of standard risk.

There has been lot of interest from the policyholders since its launch. IRDAI Chairman Mr Subhash C Khuntia while addressing participants at FICCI-FINCON 2020 shared an information that within a month general insurance companies sold nearly 15 lakh standard COVID-19 covers including both indemnity based Corona Kavach and benefit based Corona Rakshak and expressed that the high demand for the standard COVID-19 health cover shows that there is a need for such products in the market. Such standard products create trust in the minds of customers as there is no ambiguity in what is covered and what is not.The growing incidences of Covid-19 cases have made people to prioritize their health. The health insurance awareness is at an all-time high as seen in last decade.

The Corona Kavach plan remains available both on individual & family floater basis. It address the gaps observed in existing health insurance products. Depending on the severity of virus many persons may be advised by the medical practitioners to undergo homecare treatment that usually is not covered in existing health insurance products but this product duly bridges this gap.Home treatment is preferred choice of medical practitioners for asymptomatic and mildly symptomatic Covid positives who may get treatment while quarantined at home under due medical care.

It also indemnifies consumables cost that is necessary as per treatment protocol of Covid patients and which fall in the exclusionary clause of the existing products. Its features, terms and conditions bring value to customers who want cover for Covid-19 treatments.

1. It is limited period, single risk policy exclusive to covid-19 treatment. The plan comes with a cap on sum insured up to Rs five lac. Treatment cost of illnesses other than Covid or accident is not covered in this policy.
2. It only indemnifies medical expenses incurred for hospitalization for the treatment of Covid on positive diagnosis in a government authorized diagnostic centre.

3. There is no cap for room rent. It relieves insured from proportionate deductions for associated medical costs if a room of higher cost than entitled is utilized for care as prevalent in most of the existing health insurance policies.
4. Oxygen, Ventilator charges, PPE kit, gloves, masks and similar other expenses are specifically covered without any cap if hospitalized for a minimum of 24 hours. PPE kits, gloves etc. are not covered in existing health insurance policies.
5. The fees charged for surgeons, consultants, anesthetists & specialists including the consultations through telemedicine are covered.
6. In addition to in-patient care expenses on diagnosis of COVID-19 the policy also covers cost of 'Home care treatment' for up to 14 days per incident, if prescribed by medical practitioner. The cost of Pulse oximeter, oxygen cylinder and Nebulizer is covered. Existing health insurance products do not cover such expenses outside hospital. In addition to it, diagnostic tests undergone at home or at diagnostic centre, medicines &the consultation charges of medical practitioner and nursing charges related to medical staff are also indemnified,
7. For the purpose of this policy any set up designated by the government as hospital for the treatment of Covid shall also be considered as hospital.
8. Any co-morbid condition, including pre-existing co-morbid condition, triggered due to Covid-19 is covered during the period of hospitalization along with the treatment for Covid.This provides great relief and access to health insurance to those who have these conditions and found it difficult to get coverage in these difficult times.

9. It excludes unproven treatment expenses as it lack significant medical documentation to support its effectiveness. However it stipulates that treatment authorized by the government for the treatment of Covid shall be covered. So the plasma therapy, if authorized by the government will be covered and indemnified.
10. There is no deductible under this policy.
11. Lifelong renewability, portability and migration is not available under this policy.
12. Installment facility is not available as it is single premium payment short term policy with policy tenure options for 31/2 months, 61/2 months and 91/2 months.
13. Pre-hospitalization expenses incurred 15 days before hospitalization and post hospitalization expenses post 30 days of discharge are covered.
14. Policy has optional daily cash cover on benefit basis up to 0.5% of sum insured once every 24 hours of hospitalization up to 15 days to meet incidental expenses.
15. Waiting period is only 15 days. Any Covid claim manifested prior to commencement date of policy or during the waiting period is not covered.
16. Policy ceases if the insured travels to any country placed under travel restrictions by the Government.

Pricing of Corona Kavach Policy:

The product design of the Corona Kavach is standard across insurers and no changes in prescribed design are permitted. Its pricing, however is left for discovery independently on Insurers on their actuarial assumptions and evaluation of risk. The pricing remains a challenge for insurers due to lack of data or availability of insufficient data related to cost of Covid treatment, related morbidity rates, mortality rates & patient profiles.

The details of frequency and severity of corona virus treatments, the effect of including otherwise excluded cost in existing products, evolving treatment protocol and costs remaine devolving, unknown and unsettled. Long term effect on health on corona survivors remains uncertain.Prognosis and treatment remains emerging. There remains high level of uncertainty related to frequency and severity of Covid outbreaks.

These constraints resulted in discovery premium costs for these standard products that vary significantly amongst insurers. It significantly but surprisingly attracts the attention that the risk appetite and actuarial assumptions& evaluations for standard risk can be so materially different for different insurers in their rate setting process. Whether these rates are representative of being competitive in their pricing or are on factoring of all associated risk on quality data sets can honestly be best answered only by the actuaries or else the insurers may check later how their liabilities are reported& combined costs emerge actually for these limited period products against technical premiums rated for these products.

Some private insurers who have priced annual standard Arogya Sanjeevani health insurance product at very low price in April 2020 have priced limited Corona Kavach with very high price in July 2020. Some PSUs who priced the standard annual cover at very high price discovered very low price for this limited product in their actuarial modelling and evaluation of standard products. For a common man so much difference in same standard products suggests that these companies are at risk of under or over pricing the risk. Margins do vanish in a price-based competitive world. However, the prices are very attractive and affordable and will surely ease the financial pressure brought by this pandemic.

The pandemic will run its course at some point of time and the need which is felt today may not remain so relevant after a year or two. The trend of shoot up sale of this limited period product is out of fear and panic and it may last only for a short term. The revenue generated on these products may not remain available for renewals once the virus is contained and controlled. These Covid products do not seem to be a long term risk mitigation tool and these are no substitute for a regular health insurance covering all illnesses with lifelong renewable clause.

Corona Rakshak hands out a pre-agreed lump-sum to insured beneficiary upon diagnosis of Covid. The policy promises to pay up to 100% of the sum insured in a lump sum if the insured tests positive for Covid-19 and is hospitalized for a minimum of 72 hours. The policy is terminated once claim

is made and paid. This is available up to sum insured of Rs 2.5 lacs. Benefit based policies hands over the sum insured to policyholders if they are diagnosed with the covered ailments or health contingencies under the policy. This is not available when home treatment is taken. However, the set up or make shift hospital designated by the government for treatment of Covid falls under the definition of hospital to trigger the benefit under the policy. The minimum entry age for both standard Covid products is 18 years and the maximum age is 65 years.

Health Insurance Risk Landscape is changing

The health insurance is in new era. It has occupied the top segment position in non-life sector. It is developing and undergoing significant changes at all levels be it government, regulator, insurers or service providers. Government's flagship health insurance programme 'Ayushman Bharat' (PMJAY) has completed glorious two years and it has covered 13.13 crore households i.e. 53% of population base including converged State schemes. Government is inching towards Universal Health Coverage through convergence and expansion of beneficiary base.

Convergence of various schemes within State and other schemes such as ECHS, Indian Railways etc. may reduce the overlap and gain the higher efficiency by collective bargaining for lowering prices. National Health Authority has also issued expression of interest for its pilot product offering health insurance covering missing middle population. It is important to see how general and health insurers grab this opportunity. It is observed that 32 States and UTs out of 36 have implemented Ayushman Bharat.

However the programme is being implemented in 'Trust mode'. Out of 32 States and UT only seven have implemented the scheme in 'Insurance mode' and 4 have gone for 'hybrid mode'. It shows that a great opportunity of growth has been lost by insurers as the schemes in insurance mode are also going back to trust mode. This scheme has not only created awareness amongst population at large but it provides great learning for technology implementation, handling of fraud, abuse and wastage and deciding on package rates for treatment of various medical and surgical procedures.

Regulator has standardized exclusions and these shall be mandatorily applicable across all insurers in India w.e.f. 1st of October 2020. After standardizing common definitions, critical illnesses, standard protocols for network providers, minimum standard clauses in health agreements, standard discharge summaries and standard hospitals bills by network Providers and after introducing standard retail health insurance product recently in April 2020 and Covid specific products in July 2020 these guidelines will rationalize and standardize the exclusions in health insurance contracts and will provide uniformity and transparency.

It is right time for forward looking insurers to work upon their Health Underwriting Policies with defined objective criteria. Products may not address the larger aspects of corporate philosophy on broad and wider underwriting philosophy &controls. These aspects are strategically covered in the underwriting policy and it determines the Segments and Pool Company is looking forward for health portfolio. This policy provides ease in underwriting at all levels. With new PED definition, moratorium period and lifelong renewal clause it should strategically deal effectively as to how disclosures on existing diseases by the proposer should be considered by an insurer.

Some disclosures may be addressed by applying pre-defined loadings to provide coverage but in certain cases the disclosed risk may not enable the insurer to offer coverage and such risks need to be excluded permanently. If a risk is accepted it should be based on consent of proposer with disclosure of applicable loadings. The Regulation prescribes such policy to be approved by the Board of the Insurer and if no such policy exist the officials of company won't be able to have discretions for such decisions.

The pandemic is regularly challenging the engagement rules in health insurance. Standardization of health insurance contracts will set the new course of operational efficiencies. Consumers will gain more trust and faith with more standardization. This sector has already occupied the top segment position in terms of premium. Pace of recovery in late 2020 or in 2021 will depend on speed of containment of the pandemic and the effective business continuity plans of the insurers. The landscape of health insurance is changing at fast pace and Insurers shall build operational resilience to emerge as relevant insurers in this fast evolving era.

There is no prescriptive solution to drive growth or profitability in the segment but clear strategic vision as to where you want to go and who will carry you there may determine the future of players in this sector. Health is going to remain unchallenged business growth driver for health and general insurers and it is time for them to reposition their resources, engage in collaborations and come out with right products on right price to remain self-sufficient and relevant in changed landscape.

(The views expressed are purely academic and his personal capacity.) ❑

PERFORMANCE OF CROP INSURANCE SCHEMES IN INDIA

Introduction

The Comprehensive Crop Insurance Scheme (CCIS) launched in 1985 was the first large scale government subsidized crop insurance scheme in India. Both CCIS and its immediate successor the National Agriculture Insurance Scheme (NAIS) carried premium and claims subsidies from the government and the risk was exclusively carried by public sector insurers. The premium rates under both these schemes were practically fixed by the government and hence actuarial price discovery based on actual claims experience for various crops across states and districts could not take place.

It was only in 2010 that the government launched the Modified National Agriculture Insurance Scheme (MNAIS) that provided for payment of actuarial premium to insurers prior to the commencement of risk. This was the first concrete effort towards introducing a market-based crop insurance scheme. Premium rates increased substantially and as a result the claim ratios came down under MNAIS as compared to CCIS and NAIS. Meanwhile, a need was felt to move from the traditional area-yield approach to loss assessment, which is based on Crop Cutting Experiments (CCEs) undertaken by state governments,to a more transparent and quicker basis of claims settlement. The Weather Based Crop Insurance Scheme (WBCIS) was launched on a pilot basis in 2007 to address this situation. Under WBCIS claim payouts were based on underlying indices like precipitation (rainfall) instead of yield deficit as assessed by CCEs. The Revised WBCIS (RWBCIS) continues to be in operation till date.

However, RWBCIS could never fully replace the area-yield based flagship schemes. The ambitious Prime Minister's Fasal Bima Yojna (PMFBY) launched in 2016 introduced several changes like higher number of CCEs making the village as an insurance unit, pegging the farmer's premium contribution to maximum of 2.5% of the sum insured, equal sharing of the remaining part of the actuarial premium between state and central governments, introducing technology based solutions for enrolment as well as claims settlement, opening-up the scheme for bids by all

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empaneled public and private sector insurers, expanding the ambit of coverage to localized losses and delayed / failed sowing and so on. Above all, PMFBY was a big step in transforming the crop insurance sector in India from a purely farmer welfare programme to a market-based public private partnership (PPP) model.

This new approach towards crop insurance though, has already started causing jitters among many quarters. As PMFBY completes three years of operations, many state governments have either already withdrawn from PMFBY or are thinking of introducing their own schemes. Some states are thinking of setting-up their own state-level specialized crop insurance companies. On the supply side many insurance companies have stopped bidding for PMFBY as they are facing difficulties in arranging reinsurance.

Efforts to introduce remote-sensing technology for claims assessment with a view to complement or replace manual CCEs have met with partial success only. Many studies have pointed out a clear dissatisfaction of farmers over the delays caused in claim settlements despite the government introducing interest penalties on insurers. Amidst these mixed signals, an objective analysis of the performance of crop insurance in India over the last three years is attempted here, using recent data released by the government[1].

Performance of Crop Insurance Schemes

The efficacy of a publicly funded insurance programme is broadly reflected in three parameters - outreach, client (customer) value and sustainability. The performance of two major crop insurance schemes (PMFBY and RWBICS) over the last three years (2016-17 to 2018-19) on all these parameters is discussed below.

Outreach: The primary indicator of the success of a social insurance programme is its outreach among the target population. The objective of de-risking the agriculture sector and improving the risk profile of farmers can be attained only when the outreach of crop insurance is sufficiently high. Available data suggests that almost 57 million farmers were insured in 2018-19 as against 53 million in 2017-18 and 58 million in 2016-17 both Kharif and Rabi seasons put together. Thus, the number of insured has actually dropped in 2018-19 as compared to 2016-17.

A total of 34.8 million farmers had enrolled for PMFBY during Kharif 2017 (www.pmfby.gov.in) which is roughly 24% of a total of 146 million farmers (Agriculture Census 2015-16) in the country. Similarly, about 30% of the Gross Cropped Area (GCA) was insured under crop insurance in 2018-19. This points to a sizable protection gap as more than 2/3rd of total farmers in the country still remain uninsured. The outreach may decline further as enrolment in PMFBY is now purely voluntary, even for loanee farmers.

The average insured landholding during the three years was at 0.96 which is slightly lower than the national average operational holding of 1.08, thus indicating a higher than proportionate share of small holders in the insured population. Non-loanee farmers constituted about 38% of total farmers insured under PMFBY in 2019-20. With the scheme now being made voluntary for loanee farmers, this ratio might improve.

Client Value: The intrinsic value of a crop insurance product lies in the extent and spread of financial protection it offers to farmers from the pool created through collection of premium. The incurred claims ratio (ratio of premium collected to claims paid) as well as claims incidence (the proportion of farmers receiving claim payouts as against the total number of farmers insured). As can be seen from table below, the average claims ratio for the last three years has been 81.1%. In other words, out of the total gross premium of Rs 76,331 crores collected by the insurance companies, claims worth Rs 61,876 crores have been reported.

This is despite the generally good monsoon in the country during these three years. This data dispels frequent allegations of profiteering by insurers from crop insurance, as insurers also have to defray other expenses on reinsurance and administration from the premium collected. A market-based system driven by demand and supply normally does not allow stakeholders to reap undue benefits.

Claims incidence throws light on the spread of benefits among the insured population. It can be seen that the claims incidence has risen from 25.5% in 2016-17 to 29.1% in 2018-19. This means that the benefit in the form of claims is reaching more than a quarter of total insured farmers annually. Insurance is a mechanism through which contributions by 'many' compensate for the losses suffered by unfortunate 'few'. Apart from claims incidence, a steady increase can also be seen in average sum insured, average claim size, average claim per insured farmer and average claim per insured hectare. All these factors clearly indicate

[1]Except other wise stated, basic data for this analysis is drawn from replies to unstarred questions nos. 548 and 579 in Rajya Sabha given by the Government on 7th February 2020.

the increasing efficacy of the scheme from the farmers' standpoint.

Sustainability: Insurance works on the principle that the cost of risk at an individual or household level will significantly reduce when diversified risk exposures are aggregated in a portfolio. This is why the risk of yield losses that can become catastrophic for individual farmers becomes commercially viable for insurance companies. In this process reasonable profits for insurers have to be allowed, in order to ensure their sustained interest.

Despite profits, insurance remains beneficial for individuals on account of the aleatory nature of risks it covers. Hence, social insurance schemes like PMFBY need to offer adequate protection to farmers while remaining profitable for insurers. Therefore, while very low claim ratios diminish the client value of the scheme, very high claims ratios impair its sustainability. The appeal of insurance lies in attaining and maintaining a right balance between sustainability and client value.

In the last three years the average premium rate for crop insurance has gone up by almost 15% from 10.7% in 2016-17 to 12.3% in 2018-19. In a competitive bidding system with such large volumes involved an increasing premium rate indicates a correction towards sustainable pricing. On the other hand, probably because of increase in input costs as reflected in the scale of finance, the average sum insured per insured hectare has also increased by almost 27% in three years.

Both these factors have had a compounding effect on the average premium per insured farmer and insured hectare which have increased by 37% and 46% respectively. Correspondingly, like the claim ratio, the average claim size has also gone up by almost 25% from Rs 11,258 in 2016-17 to Rs 14,038 in 2018-19. This has in turn, rippled into an increase of almost 42% and 52% in average claim per insured farmer and insured hectare respectively. Here it is pertinent to note that the farmers' share in the gross premium has actually gone down from 19.2% in 2016-17 to 16.9% in 2018-19, the rest being subsidized by state and central governments.

This means that the burden of attaining sustainability for the scheme is not being passed on the farmers but is borne by the government. While this is fine for the farmers, the fiscal burden for the government is rising. This perhaps explains the recent decision of Central Government to reduce its share in the premium subsidy for PMFBY from 50% to 25% in irrigated areas and 30% in non-irrigated areas. Social insurance needs to be sustainable not just for the risk carrier but also for the government that rolls out huge subsidies as well as the farmers who also pick-up a part of the cost.

It is actually a healthy sign to see a variety of market forces at play trying to balance the equilibrium of crop insurance in the country. A market-based system keeps evolving according to the market dynamics which in turn helps the sector in discovering the right balance between sustainability and client value so that a palpable de-risking of agriculture sector takes place. Only then can a win-win situation emerge for all stakeholders.

Conclusion

To sum up, the above data reveals that crop insurance schemes in India are moving in the right direction towards gaining scale, client value and sustainability. Agriculture insurance schemes however, need to be evaluated on a bigger longitudinal timeframe for any definitive conclusions.

Crop Insurance Performance 2016-2019 (PMFBY and RWBCIS)

Year	Average Premium Per Farmer (Rs.)	Average Premium Per Ha (Rs.)	Average Sum Insured Per Ha (Rs.)	Average Premium Rate (%)	Claims Incidence (%)	Claims Ratio (%)	Average Claims Size (Rs.)	Average Claim Per Insured Farmer (Rs.)	Average Claim Per Insured Ha (Rs.)
2016-17	3,748	3,832	35,842	10.7%	25.5%	76.7%	11,258	2,874	2,939
2017-18	4,801	4,922	39,697	12.4%	33.1%	86.5%	12,536	4,153	4,257
2018-19	5,123	5,605	45,502	12.3%	29.1%	79.6%	14,038	4,079	4,463
Total	4,544	4,756	40,204	11.8%	29.1%	81.1%	12,654	3,684	3,855

Kharif 2018 and Rabi 2018-19 Claims figures are provisional

Having said this, the fact also remains that agriculture in general and crop insurance in particular are sensitive topics and therefore fraught with complexities of perception, going much beyond sheer data. More than the technical parameters like claim ratios and outreach, various behavioural factors also influence the discourse on crop insurance which cannot be ignored. Agrarian economics in India has largely remained welfare-centric and has not quite promoted a business-oriented approach towards agriculture.

These tendencies inhibit the transformation of agriculture from a last-recourse activity to a full-fledged business and thus make the introduction of market-based systems like PMFBY a bit arduous for all stakeholders. This is why on one hand there are allegations of 'windfall gains' by insurance companies while on the other fewer insurers now come forward to bid for PMFBY. Furthermore, the farmers still prefer the manual CCE based loss assessment despite its inherent problems, while the insurers prefer index-based products. Several such antagonisms prevail at the ground level.

Therefore, a more holistic analysis that considers not just data but also the behavioural tendencies of various stakeholders at play, including the insurers, needs to be carried out, in order to ascertain the real issues that confront crop insurance sector so that workable long-term solution can be suggested.

Green Delta advisor honored with'lifetime achievement award'

Green Delta Insurance Company's (GDIC) Advisor and Founding Managing Director Nasir Ahmad Choudhury is honored with 'lifetime achievement award' by an international forum in India for outstanding contribution in insurance inclusion in Bangladesh.

Nasir Ahmad Choudhury
Founding MD, GDIC

Indian Birla Institute of Management Technology (BIMTECH) announced the recognition to the Bangladesh veteran in insurance sector at fourth edition of BIMTECH Insurance Colloquium held virtually on Friday.

Insurance Regulatory and Development Authority of India (IRDAI) member TL Alamelu made keynote in the session while BIMTECH Director made address of welcome on the occasion.

BIMTECH Prof Abhijit K. Chattoraj conducted the first thematic session on 'challenges from corona pandemic to health insurance industry and way out'.

Green Delta Insurance Managing Director Farzanah Chowdhury, Max Bupa Health Insurance Director Bhabatosh Mishra, IRDAI General Manager D V S Ramesh, World Bank Senior Consultant MaltiJaswal, Star Health & Allied Insurance Managing Director S Prakash shared knowledge in the session.

Regarding the achievement, GDIC Managing Director Farzanah Chowdhury said the achievement of our respected advisor added another feature of success as NasirAhmad Choudhury has shown pathway of insurance inclusion in Bangladesh.

DBH chairman Nasir Ahmad Choudhury, a widely respected business veteran, pioneered the insurance industry of Bangladesh.

After completing post-graduation from Dhaka University, Nasir Ahmad joined the Pakistan Insurance Corporation in Karachi in September 1958. Later, he went to London for training and further traveled to Germany to train at the Munich Reinsurance Company.

At Pakistan Insurance Corporation, he held various senior positions till the liberation of Bangladesh. In 1972, fueled by the patriotic urge to engage in nation building, he took up the challenging responsibility of re-building the reinsurance department of the Sadharan Bima Corporation as a General Manager.

In 1985, when insurance was opened up to the private sector, Nasir Ahmad established Green Delta Insurance with a couple of close friends, as sponsor and founder managing director and chief executive officer.

The seasoned businessman was director at FBCCI, President of the Insurance Association, executive member of the Metropolitan Chamber of Commerce and Industry, president of the Bangladesh German Commerce and Industry.

CONSUMER PROTECTION ACT 2019: CHANGING TIME TO OWN PRODUCT LIABILITY INSURANCE?

Abstract

The consumer protection act 2019 has come into effect from 20 Jul 2020 which has replaced the three-decade-old act. New mechanisms to protect the rights of consumers, the establishment of the Central Consumer Protection Authority (CCPA), easier to file the complaints are a few of the steps which shall protect the rights of the consumers. The manufacturer, the retailer may be liable for compensation if the products or services sold caused harm or injury to the consumer. The product liability insurance which aims to protect the insured from huge legal expenses including compensation awarded by courts may come to the rescue and can save from huge financial losses to the insureds for inadvertent goods.

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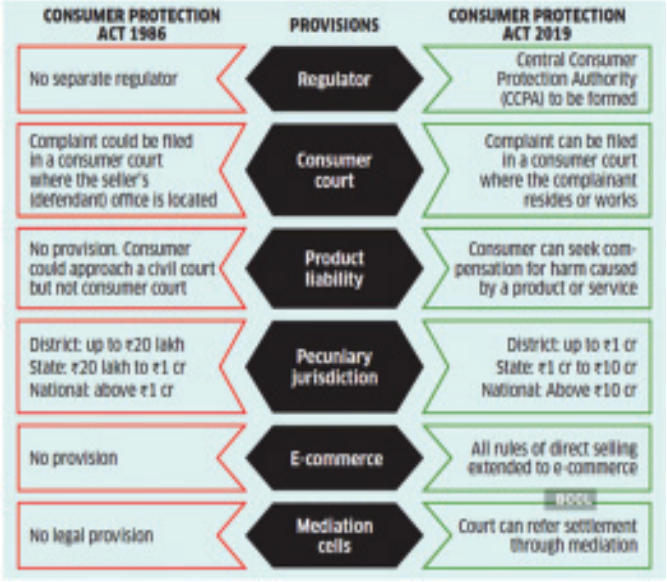
Consumer Protection Act, 2019

Consumer Protection Act 2019 (CPA 2019) received the assent of the President of India on 09 Aug 2019 and came into effect from 20 Jul 2020 thus replacing the three-decade-old Act. There has been a continuous rising of court cases also digital era and e-commerce services have been increased manifolds, thus a strong need to have changes in the act was deliberated over some time. To protect the rights of the consumer and smoothen the process of filing cases CPA 2019 will ease the process of redressal of grievances and bring consumer awareness.

Highlights of CPA 2019

- New terms like advertisement, product, product liability, e-commerce has been introduced in the act.
- The definition of the consumer has been widened to cover the e-commerce transaction. In the earlier version of the act, e-commerce transactions were not specifically included. This lacuna has been redressed in the act. Now all types of e-commerce entities related to the sale of goods, services& their returns, refunds have been brought under the ambit of the act.

- Enhanced pecuniary limits District Commission (formerly District forum) now can entertain consumer complaints up to Rs. 1 crore which earlier was up to Rs. 20 Lakh only. Likewise, pecuniary limits of State Commission revised for more than Rs. 1 crore to Rs. 10 crores (earlier Rs. 20 Lakh to Rs. 1 Cr). National Commission has jurisdiction above Rs. 10 crores.
- Electronic filing- Earlier consumer had the right to file the complaints at the place of purchase of merchandise or at a place where the seller has the registered office. Now this condition has been done away with. This act covers the electronic transactions explicitly which were not covered in the earlier act. Now complaints can be filed electronically and hearing can be using video conferencing.
- Establishment of the Central Consumer Protection Authority (CCPA). CCPA has been constituted with the vision to protect, promote and enforce the rights of the consumer. It is having powers to investigate, impose penalties, recall, refund, regulate cases pertaining to unfair trade practices, misleading advertisements and protection of consumer rights.
- Penalties for misleading advertisements. Fine of up to Rs. 1 crore and/or imprisonment upto 2 years on the manufacturer, endorser for false and misleading advertisements can be imposed by CCPA
- This act provides resolution of disputes through Alternate Dispute Resolution (ADR) methods. Mediation cells shall be formed under the aegis of consumer commissions for early settlements of disputes. This will make adjudication simpler and quicker and alleviate the pressure of an increasing number of cases on courts who already have numerous cases pending before them. If the mediation fails normal hearing will resume at the commission.



Source: https://economictimes.indiatimes.com/

Liability Insurance in India.

Liability insurance policies are typically meant for coverage for legal costs and payouts imposed by lawsuits, if found legally liable. In India, we see statutory liability policies i.e. Third Party motor (TPL) Policies and Workmen compensation (WC) are prevalent as these are mandatory in nature by compulsion of motor vehicle act and workmen compensation act. Other forms of liability policies like professional indemnity, CGL, D & O, Product liability are lesser prominent.

In India, before the enactment of CPA 2019, there was no specific statute that can exclusively cover the disputes pertaining to product liability. In the absence of statutory law, courts were guided by the principles of justice, equity and a good conscience and frequently guided by the provisions of English Law. The famous cited case of Donoghue v. Stevenson lays down the position where one owes a duty of care to another, and if such duty of care is breached, there is negligence irrespective of whether any contractual relationship exists between the parties or not. In this famous case, Mrs. Donghue went to the café along with her friend. Her friend bought ginger beer.

The bottle containing ginger beer was opaque. Mrs. Dongue drank a little beer from the bottle & then pour the rest into a glass. Along with beer, a dead snail lands in the glass. Mrs. Donghue suffered from gastroenteritis and shock. She sued the manufacturer of ginger beer. The House of Lords held that the manufacturer was liable to pay

damages to Mrs. Donghue. This case laid the foundation of the modern law of negligence. In the Indian context, following certain laws touches the issue of product liability such as

- The Consumer Protection Act, 1986;
- The Indian Contracts Act 1872;
- The Sale of Goods Act 1930;
- The Drugs and Cosmetics Act, 1945; and
- The Prevention of Food Adulteration Act, 1954.
- Food Safety and Standards Act, 2006;
- Bureau of the Indian Standards Act, 1986;
- Agricultural Produce (Grading and Marking) Act, 1937;

Product Liability and Consumer Protection Act, 2019

With the enactment of the Consumer Protection Act, 2019, the ambit of the earlier Consumer Protection Act, 1986 has been broadened with the aim to simplify the dispute redressal process, cater to fill the gap due to the ushering of the digital era, overhaul the process and settlement of consumer disputes, establishment of Central Consumer Protection Authority are provisions which may necessitate having product liability insurance for manufacturers, retailers etc.

The Act defines product liability as "the responsibility of a product manufacturer or product seller, of any product or service, to compensate for any harm caused to a consumer by such defective product manufactured or sold or by a deficiency in services relating thereto." This will impact not only the manufacturer who will be liable to compensate a consumer but also the seller if it fulfills the conditions mentioned in the Act. The Act allows a person to raise a product liability action by means of filing a complaint before a District Commission or State Commission or National Commission electronically, making the process simpler and consumer-friendly.

Each year few products keep on making news sometimes due to wrong reasons, it may be exploding battery of famous mobile phone company or issue of undesired content in famous noodles in recent times.

Product liability insurance is a branch of liability insurance. Product Liability insurance protects the insured against the

claims which may arise due to personal injury, property damage harm by the products sold or supplied through the business. The cost of product liability insurance varies on various factors, coverages etc. However, the following case may be of help to ascertain the importance to own adequate liability insurance.

The famous case of product liability in the US history is the case of Liebeck vs. McDonald's in 1994. In this case, Stella Liebeck accidentally poured hot coffee bought from McDonald's over her thighs and groin area. The spillage of hot coffee caused third-degree burns. Liebeck's lawyers argued that the company served coffee at a temperature of 180 to 190 degrees Fahrenheit while other companies served coffee only at around 140 degrees. Liebeck was awarded a jury verdict of $2.7 million in punitive damages and $160,000 for medical expenses.

In the wake of CPA 2019 which broadly covers product liability, the time has come to ponder the necessity of product liability for any business big or small it may be, which manufacture, supplies the products as wholesaler/ retailer. The products which appear entirely safe sometimes have a tendency to go wrong or to cause damage due to product failure. Manufacturers and suppliers can be held liable jointly or severally as per the merits of the case. In Ram Shankar Yadav vs JP Associate Ltd I (2012) CPJ 110 NCDRC paragraph 5, the NCDRC observed: 'In any case, it is settled law that for any manufacturing defect in a product, it is the manufacturer and not the dealer who could be held liable.'

When it is difficult to held manufacturer liable due to many other reasons like presale storage (e.g. storage of cement, chocolates, ice-creams etc.) then manufacturer, dealer, retailers can be held jointly or severely liable (Bhopal Steels

vs Govind Lal Sahu & Others III (2008) CPJ 89 NCDRC & Mrs. Rashmi Handa, & Ors v OTIS Elevator Company (India) Ltd & Ors I (2014) CPJ 344 (NC) In Tata Motors vs Rajesh Tyagi and HIM Motors Show Room-II (2014)(1) CPC267, the NCDRC held that:

"We have also taken a view that onus shifts to the manufacturer to show that the vehicle does not suffer from manufacturing defect once the complainant has proved and discharged the initial onus that the vehicle was defective on the basis of large number of job cards showing that vehicle was taken on many occasion for removing one defect or the other. goods sold to the consumer is not only defective but also suffers from manufacturing defect."

The action for product liability can be invoked under CPA 2019 against manufacturer/ supplier if the Product is defective and/ or consumer is charged excessively and/or there are unfair trade practices by the trader.

In order to file a claim under liability, it is mandatory to prove that product was defected and these defects made the product harmful and caused damages. The defects can be categorized broadly in three categories which may give rise to manufacturer or supplier liability.

Design Defects **-** The defects are caused at the planning phase itself even before the manufacturing. Such defects make the product inherently unsafe.

Manufacturing Defects **-** These defects enter in the product during the manufacturing or assembling of the product.

Marketing Defects **-** inadequate safety warnings, inadequate or incomplete instructions, improper labeling etc. are marketing defects.

Once the consumer has decided to raise the issue the following doctrines shall come to the aid of the consumer.

Res ipsa loquitur (Latin: "the thing speaks for itself") is a doctrine in the Anglo-American common law which shifts the burden of proof to the defendant(s). It means if the doctrine invoked effectively, the consumer has not to establish but it shall be the defendant(s) to prove in the court of law that it was not negligent.

Another rule which becomes handy to plaintiffs (consumer in relevance to CPA 2019) in product liability cases is the doctrine of strict liability. If strict liability applies successfully, the plaintiff needs to prove that product was defective. There is no further need to prove that a manufacturer/ supplier was negligent. However, the consumer shall not have any defence available if they have modified, altered, misused the product or failed to follow the security and warning instructions.

Product Liability Insurance needs of the hour?

The product liability insurance policies shall indemnify the insured against their legal liability to pay compensation including legal expenses of claimants in accordance with the law of the land. Most product liability policies shall exclude settlements made in countries that operates under the law of US & Canada.

Product liability policies are a specific form of general liability policies which meant to protect from financial & legal consequences which might be caused by bodily injury, property damage to third party while using the product. There are always chances for something to go wrong and manufacturer or suppliers may be vicariously held liable to own up the damages. This may give rise to a legal dispute. Although one may want to fight back and may win the case but the legal expenses to win the battle might be very high. Thus product liability insurance may protect against any claim made by the customer arising due to injury caused by the use of the product.

Usually, it is assumed that liability policies should be owned by big business houses. Now when the Indian economy is thriving and society is becoming litigious with the awareness of one's rights, easy access to various redressal forums, the time has come when every business houses including startups should consider owning a product liability insurance. A small baker, boutique owners, florists, wholesalers, restaurants, food stores can have liability policies to cover themselves

from huge legal expenses. A claim may be triggered if a child playing with a toy has swallowed part of the toy or scare marks turned on the skin while undergoing a routine visit to a beauty salon.

It shall be kept in mind that such policies shall come with certain warranties. Insurers can impose certain warranties like while taking insurance for swimming pools, the warranties can be pool shall be maintained in hygienic conditions along with proper arrangements of safety and operation, availability of lifeguards when the pool is operational. For food & beverages the imposed warranties may be like insured shall all time maintain hygienic conditions, insured shall take every precaution to ensure food supplied is contamination-free and fit for human consumption with proper packaging etc.

Liability insurance policies are usually claim made policies and have certain exclusions. These policies do not cover any pure financial losses like loss of goodwill, contractual liabilities, acts of god, liability arising out of any fines, penalties, deliberate non-compliance of statutory provisions shall remain major exclusions under product liability insurance policies.

Conclusion.

The liability Insurance market in India is growing at 10.3% and presently of about Rs. 3000 crores. Liability insurance like other branches of insurance protects the insured against the huge financial losses which may arise due to huge legal costs & awards. In the current scenario due to pandemic, the world economy is at the verge of global recession, cyber-attacks, as well as cyber frauds, have increased manifolds and this may spur demand for other types of liability insurance policies.

This is the time when not only manufacturers but wholesellers, retailers should adequately cover themselves with product liability insurance. With the enactment of CPA 2019, the consumer shall have various rights and it shall be the duty of manufacturers, retailers to service their clients honestly and diligently.

Rising incomes, techno-savvy younger generation, huge consumer demands shall continue to attract large companies to come and invest in India. It shall be a win-win situation for consumers as well as companies with the growth of the Indian economy. Thus CPA 2019 was the need of the hour and also the time has come when all the interested parties to look into &seek coverages against legal expenses which may arise due to any product failure. The new legislation comes with a bundle of accountabilities and responsibilities on manufacturers, suppliers and retailers to serve the consumer and in a true sense making the consumer the real king.

Reference:

Various Sources.

More mediclaim buyers use EMIs to buy policies

Non-life insurers are seeing rising demand for health policies under the equated monthly instalment (EMI) option. Insurers attribute this to reduced affordability due to a fall in income and job losses, even as the need for a cover has gone up due to the pandemic.

In September 2019, the Insurance Regulatory and Development Authority of India (Irdai) allowed companies to sell policies with monthly, quarterly or yearly mode of payment. After the Covid pandemic broke out, in April this year, Irdai directed insurers to extend this facility. Over a dozen companies now offer this option.

Most people opting for EMI mode are new-to-insurance customers. “As high as 40-45% in the EMI segment are first-time buyers. About 40% opt for health coverage of Rs 5-10 lakh, and another 40% opt for the Rs 25 lakh-Rs 1 crore sum insured,” said Policybazaar business head (health) Amit Chabra.

Over 70% of customers opt for family floaters. “With Covid, salaried people have lost their jobs or suffered pay cuts while self-employed have seen the loss of revenue and cash flow issues. The coronavirus pandemic has heightened fears. For many, the EMI option is the most prudent one,” said Gurdeep Singh Batra, national head (retail underwriting) at Bajaj Allianz General Insurance, which has offered an EMI option since August.

Insurers say that the EMI option costs 2% more to cover their increased working capital costs. “We have to send reminders, our staff has to contact customers. But it makes selling easier as a monthly payment of Rs 500-800 doesn’t really set someone back,” said Batra.

EFFECTUAL INSURANCE UNDERWRITING IN THIS DECISIVE JUNCTURE OF NEW NORMAL SITUATION

Introduction:

The coronavirus pandemic is savaging the global economy, resulting in widespread business closures, near-universal event cancellations, insurance executives are habitually working from home & busy in attending/responding the mails of bosses, insured, intermediaries, like brokers, Surveyors, etc., Event Managers are working on the cancellation of events, cancellation of orders and slowing of deliveries are obvious, and a general disruption of supply chains is evident.

News reports indicate that the impacts are already being felt in virtually all industries. Travel, transportation, hospitality, education, health care, entertainment, and event planning are especially hard-hit, but most manufacturing and service activities are being disrupted. In recent days, the insurance industry had cut back on coverage available for pandemic diseases, introducing new or broadened exclusions and applying strict sub-limits to contain insurer exposure. Nonetheless, pockets of coverage continue to exist. So it is important now to make revised assessments of Insured business's vulnerabilities and Indian Insurers need to resort to underwriting prudence and also to seriously depend on their underwriters' acumen.

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Market discipline to be imbibed in underwriting:

Underwriting is a process of selecting policyholders by recognizing hazards, analyzing risks, determining pricing, deciding terms and conditions. It is a process of gathering information about a risk offered for insurance and deciding coverage with proper premium and terms. Functions like marketing, ratemaking, accounts and claims may be subcontracted to outside agencies, but not underwriting because of its fundamental importance to the success of the insurer. To develop and maintain a profitable book of business is the main purpose of underwriting. This comes from proper selection of risks. To achieve this purpose, the

insurers (underwriters) must avoid adverse selection. Adverse selection occurs when the proposed risks present a higher-than average probability of loss. Underwriting control ensures no adverse selection at operating level and corporate underwriting policy is not giving adverse results.

Underwriting is a core insurance function. It is a methodological approach to ensure that the insurance business is conducted on sound lines and that risks offered for insurance are evaluated for loss potential on both frequency and severity over a period of time over which the liability may flow to the insurer. In short the underwriter does a proper exercise to evaluate the insurability of the risk and if the risk can be assumed, the price, terms and conditions at which the risk may be insured.

Underwriting is the process of:

1. Determining the level of risk presented by a proposer
2. Deciding whether to accept the proposal
3. Deciding the terms and price of the accepted proposal

Each underwriting decision involves balancing the insurer's desire to earn premium often in competitive conditions with margins required to pay claims and expenses and also to ensure compliance with regulatory requirements.

Underwriting is essential in all forms of insurance. For example, an automobile insurer may charge higher rates to old models of vehicles, or may refuse coverage to drivers with a history of accidents. The underwriter may offer discounts for vehicles fitted with anti-theft devices or having membership of Automobile Association, etc. Fire insurers may inspect properties, offer reduced premiums for safety features such as hydrant or sprinkler systems, and so on.

Understanding risk sharing in insurance:

Understanding the concept of risk sharing or pooling will make it easier for everyone to understand the role of underwriting and risk classification in insurance.

All risks are not equal. For example, in the field of property and casualty insurance, wooden structures are at a greater risk of burning than stone structures. Therefore, a higher premium is required to insure a wooden structure. The same concept applies to life insurance. An individual with a serious illness such as cancer or diabetes is at a greater risk of premature death than an individual without the illness.

Since all risks are not equal, it would be inequitable to make all insured contribute the same amount. Thus, underwriting attempts to classify risks based upon their characteristics so that each insured in a specific class pays a premium in proportion to the risk involved.

The issue of fairness to the other participants is at the core of this risk classification (underwriting) process. When viewed from a perspective of fairness, proper risk classification becomes a central obligation of insurers to the policyholders who participate in their risk pools. This applies for all risks - life, assets or earnings.

We all know that Insurance is a contract by which one party, the policyholder, pays a stipulated consideration, called premium, to the other party called insurer. In return, the insurer agrees to pay a defined amount of money or provide a defined service if the covered event occurs during the policy period. So Insurance is a risk transfer-cum-sharing or pooling of risks. It is created when people pool their contributions to create a common fund that is large enough to protect themselves from the effects of a loss which may affect any one or more of them.

The loss could be of any type - life, disability, fire or more. If the risk of loss can be spread over a large group (the law of large numbers), the financial loss resulting from the loss to the members can be paid from the premium collected for the pool. This is in contrast to one person bearing the full brunt of economic loss without any financial backing. Thus, in insurance a large uncertain loss is replaced for a small certain loss of the premium.

Premium fixation - the essence of underwriting:

Insurance is a trade that runs on premium collected from

the policyholders. So those insurable risks have to be understood and differentiated in the interest of impartiality and equity. The simple fact is that practically no two risks may be equal in all respect. There are physical hazards involved and several objectives are inherent - such as variations in construction, occupancy, neighbourhood exposures, protective measures available and management attitudes relating to each risk to be underwritten.

The underwriter therefore, has to excel in risk classification so that each insured pays the premium in proportion to the likely hood that a covered loss might strike it. Every insured has to share in the risk burden based on its risk load and that has to be properly assessed by an underwriter, who needs to keep reviewing the risk so that any betterment in it to be rewarded and any increase in the risk exposure must be charged higher in proportion to the increase in the risk profile. The insurers assumes the risk that they takes on, by charging appropriate premium and settings the mandatory & voluntary excesses / deductibles, and deciding on the terms of coverage, conditions, exclusions and other restrictions in terms of warranty / limitations. If an insurer charges lesser than what is a proper risk-based premium across risks, it could become insolvent when large numbers of claims, whether owing to frequency &/or with higher magnitude/severity occur.

This is not only against the interests of the insurers, but against the interests of the policyholders who will need indemnity in the imminent. On the other hand, if an insurer charges too much, it will lose business to its competitors. Charging a premium too low or too high is against the principles of insurance and it also violates the Regulatory Benchmarks set by IRDAI. The right balance in underwriting and pricing is sensitive, and the Actuary and Chief Underwriter of the insurer have to ensure that proper principles and practices are inserted in the insurer's day-to-day activities under the supervision of their Board Members.

Risk appraisal, assortment & selection:

Risk appraisal obviously is the starting point of the underwriter; using the acumen of the underwriter he/she must examine the insurance proposal from its insurability standard and subsequently assigning the risks to be accepted to the relevant & appropriate class to decide whether to be accepted with the discount or loading depending on its positive or negative aspects that prevails in reality.

This process is obvious to avoid adverse selection. Adverse selection occurs when wrong information of the risk, in

detrimental to the underwriter's understanding the real risk exposure, as received from the insured being provided in the Proposal Form while that is accepted by the insurer. Underwriting depends on obtaining the correct/factual information submitted by the Proposer while filling the Proposal Form and evaluating the information that is elicited from that and finally applying his/her experience & knowledge to evaluate the proposed risk in its risk context and then deciding his action - whether to apply discount or loading on the prescribed tariff/guideline rate.

Underwriting involves examining material disclosures in the proposal forms, and other supplementary underside documents such as additional questionnaires, Inspection Reports, Valuation Reports, the market exposure/knowledge lying with the Insurer including data on similar risks and so on. Using analytics and other digital and technological tools are also becoming a requirement in this current era to arrive at the proper underwriting decisions.

Adverse selection to be always averted:

The most common risk of Indian General Insurance underwriting is adverse selection. If the two groups of dissimilar risk exposures were charged the same rate, problems would arise. Basically the rates should always reflect average loss costs. If we cover more number of perils (i.e. causes of losses) or more hazardous items - the rate should obviously increase. The insured even knowing that they represent higher risk but always want to enjoy lower rates.

This phenomenon of selecting an insurer that charges lower rates for a specific risk exposure is known as 'Adverse Selection' because the insured know they represent higher risk, but want to enjoy lower rates. Adverse selection occurs when insurance is purchased more often by people/ organizations with higher than average expected losses than

by people/ organizations with average or lower than average expected losses. That is, insurance is of greater use to insured whose losses are expected to be high.

So it is desired in underwriting that insurers may simply charge higher premiums to the insured with higher expected losses. Here comes the problem of intense competition in this free market underwriting. Often, however, the insurer simply does not have enough information to be able to distinguish completely among insured. Furthermore, the insurer wants to aggregate in order to use the law of large numbers. Thus, some tension exists between limiting adverse selection and employing the law of large numbers.

Adverse selection, then, can result in greater losses than expected. Insurers try to prevent this by learning enough about applicants for insurance to identify such people so they can either be rejected or put in the appropriate rating class of similar insured with similar loss probability. In this fierce competition in this Indian General Insurance market, underwriters have practically very limited scope in this direction where the demand now-a-days is to match the market or to quote for becoming L1 to book the client's insurance business.

Some insurance policy provisions are designed to reduce adverse selection. The pre-existing condition provision in health insurance policies is designed to avoid paying benefits to people who buy insurance because they are aware, or should be aware, of an ailment that will require medical attention or disable them in the near future. It is, therefore, desired by the underwriters that the insurance device should be suitable to all pure risks but ironically as a practical matter, many risks that are insured meet these requirements for insurability only partially or, with reference to a particular requirement, or not at all.

Thus, in a sense, these requirements to be listed & be described the ideal requisites for insurability which would be met by the ideal risk. No insurer can safely disregard them completely. Any risk that is perfectly suited for insurance coverage in Indian market would basically need to meet the following requirements:

1. The number of similar exposure units would be large.
2. Losses that occurred would be accidental.
3. A catastrophe needs to be a remote possibility.
4. Losses would be definite and the probability distribution of losses would be determinable.
5. Insurance coverage cost would be economically feasible.

Actually the item no. 5 influences the consumer demand for insurance and looks at what is economically feasible & viable from the perspective of potential insured. Other requirements (i.e. item nos. 1 to 4) influence the willingness of insurers to supply desired insurance cover.

Issue of fair pricing in insurance market:

In a free market society, an entity offering a product for sale should try to set a price at which the entity is willing to sell the product and the consumer is willing to purchase it. Determining the supplier-side price to charge for any given product is conceptually straightforward. The simplest model focuses on the idea that the price should reflect the costs associated with the product as well as incorporate an acceptable margin for profit. The following formula depicts this simple relationship between price, cost, and profit: Price = Cost + Profit.

This is however, true in case of a tangible product. It is also to be noted that for many non-insurance goods and services, the production cost is known before the product is sold. Therefore, the initial price can be set so that the desired profit per unit of product will be achieved. However, Insurance is different from most products as it is a promise to do something in the future if certain events take place during a specified time period. For example, insurance may be a promise to pay for the rebuilding of a home if it burns to the ground or to pay for medical treatment for a worker injured on the job. Unlike a can of soup, a pair of shoes, or a car, the ultimate cost of an insurance policy is not known at the time of the sale. This places the classic equation in a somewhat different context and introduces additional complexity into the process of price setting for an insurance company.

The price the insurance consumer pays is referred to as premium, and the premium is generally calculated based on

a given rate per unit of risk exposed. Insurance premium can vary significantly for risks with different characteristics. The rating manual is the document that contains the information necessary to appropriately classify each risk and calculate the premium associated with that risk. The final output of the ratemaking process is the information necessary to modify existing rating manuals or create new ones.

The earliest rating manuals were very basic in nature and provided general guidelines to the person responsible for determining the premium to be charged. Over time, rating manuals have increased in complexity. For some lines, the manuals are now extremely complex and contain very detailed information necessary to calculate premium. Furthermore, many companies are creating manuals electronically in lieu of paper copies. Before, understanding the complex process of insurance pricing and ratemaking, it is important to be familiar with some basic insurance terminology used in the pricing process for better understanding.

The basic economic relationship for the price of any product was given as follows:

Price = Cost + Profit.

This general economic formula can be tailored to the insurance industry using the basic insurance terminology outlined in the preceding section. Premium is the "price" of an insurance product. The "cost" of an insurance product is the sum of the losses, claim-related expenses, and other expenses incurred in the acquisition and servicing of policies. Underwriting profit is the difference between income and outgo from underwriting policies, and this is analogous to the "profit" earned in most other industries. Insurance companies also derive profit from investment income, although at this juncture this aspect of profit for the insurers is relatively drab.

The goal of ratemaking is to assure that the fundamental insurance equation is appropriately balanced. In other words, the rates should be set so that the premium is expected to cover all costs and achieve the target underwriting profit. Thus, a rate provides for all costs associated with the transfer of risk. There are two key points to consider in regards to achieving the appropriate balance in the fundamental equation:

1. Ratemaking is the current prospective.
2. Balance should be attained at the aggregate and individual levels.

Ratemaking is the current prospective:

As stated earlier, insurance is a promise to provide compensation in the event a specific loss event occurs during a defined time period in the future. Therefore, unlike most non-insurance products, the costs associated with an insurance product are not known at the point of sale and as a result need to be estimated. The ratemaking process involves estimating the various components of the fundamental insurance equation to determine whether or not the estimated premium is likely to achieve the target profit during the period the rates will be in effect.

It is common ratemaking practice to use relevant historical experience to estimate the future expected costs that will be used in the fundamental insurance equation; this does not mean actuaries are setting premium to recoup past losses. As per the principle in the CAS Statement of Principles Regarding Property and Casualty Insurance Ratemaking" states that "A rate is an estimate of the expected value of future costs". Historic costs are only used to the extent that they provide valuable information for estimating future expected costs.

When using historic loss experience, it is important to recognize that adjustments will be necessary to convert this experience into that which will be expected in the future when the rates will be in effect. For example, if there are inflationary pressures that impact losses, the future losses will be higher than the losses incurred during the historical period. Failure to recognize the increase in losses can lead to an understatement of the premium needed to achieve the target profit.

There are many factors that can impact the different components of the fundamental insurance equation and that should be considered when using historical experience to assess the adequacy of the current rates.

The following are some items that may necessitate a restatement of the historical experience:

1. Rate changes
2. Operational changes
3. Inflationary pressures
4. Changes in the mix of business written
5. Law changes

The key to using historical information as a starting point for estimating future costs is to make adjustments as necessary to project the various components to the level expected during the period the rates will be in effect. There should be a reasonable expectation that the premium will cover the expected losses and expenses and provide the targeted profit for the entity assuming the risk.

When considering the adequacy or redundancy of rates, it is important to ensure that the fundamental insurance equation is in balance at both an overall level as well as at an individual or segment level. Equilibrium at the aggregate level ensures that the total premium for all policies written is sufficient to cover the total expected losses and expenses and to provide for the targeted profit. If the proposed rates are either too high or too low to achieve the targeted profit, the company can consider decreasing or increasing rates uniformly.

In addition to achieving the desired equilibrium at the aggregate level, it is important to consider the equation at the individual risk or segment level. Principle 3 of the CAS "Statement of Principles Regarding Property and Casualty Insurance Ratemaking" states "A rate provides for the costs associated with an individual risk transfer" (CAS Committee on Ratemaking Principles, p. 6). A policy that presents significantly higher risk of loss should have a higher premium than a policy that represents a significantly lower risk of loss.

For example, in workers compensation insurance an employee working in a high-risk environment (e.g., a steel worker on high-rise buildings) is expected to have a higher propensity for insurance losses than one in a low-risk environment (e.g., a clerical office employee). Typically, insurance companies recognize this difference in risk and vary premium accordingly. Failure to recognize differences in risk will lead to rates that are not equitable.

Rate making is the determination of what rates, or premiums, to charge for insurance. A rate is the price per unit of insurance for each exposure unit, which is a unit of liability or property with similar characteristics. For instance, in property and casualty insurance, the exposure unit is typically equal to Rs. 100 of property value, and liability is measured in Rs. 1,000 units. Life insurance also has Rs. 1000 exposure units. The insurance premium is the rate multiplied by the number of units of protection purchased.

Insurance Premium = Rate X Number of Exposure Units Purchased.

The difference between the selling price for insurance and the selling price for other products is that the actual cost of providing the insurance is unknown until the policy period has lapsed. Therefore, insurance rates must be based on predictions rather than actual costs. Most rates are determined by statistical analysis of past losses based on specific variables of the insured. Variables that yield the best forecasts are the criteria by which premiums are set.

However, in some cases, historical analysis does not provide sufficient statistical justification for selling a rate, such as for earthquake insurance. In these cases, catastrophe modeling is sometimes used, but with less success. Actuaries set the insurance rate based on specific variables, while underwriters decide which variables apply to a specific insurance applicant.

Because an insurance company is a business, it is obvious that the rate charged must cover losses and expenses, and earn some profit. But to be competitive, insurance companies must also offer the lowest premium for a given coverage. Moreover, all states have laws that regulate what insurance companies can charge, and thus, both business and regulatory objectives must be met.

The primary purpose of ratemaking is to determine the lowest premium that meets all of the required objectives. A major part of ratemaking is identifying every characteristic that can reliably predict future losses, so that lower premiums can be

charged to the low risk groups and higher premiums charged to the higher risk groups. By offering lower premiums to lower risk groups, an insurance company can attract those individuals to its own insurance, lowering its own losses and expenses, while increasing the losses and expenses for the remaining insurance companies as they retain more of the higher risk pools. This is the reason why insurance companies spend money on actuarial studies with the objective of identifying every characteristic that reliably predicts future losses.

Note that both the ratemaking and the underwriting must be accurate. If the rate is accurate for a particular class, but the underwriter assigns applicants that do not belong to that class, then that rate may be inadequate to compensate for losses. On the other hand, if the underwriting is competent, but the rate is based on an inadequate sample size or is based on variables that do not reliably predict future losses, then the insurance company may suffer significant losses.

The pure premium, which is determined by actuarial studies, consists of that part of the premium necessary to pay for losses and loss related expenses.

Loading is the part of the premium necessary to cover other expenses, particularly sales expenses, and to allow for a profit.

The gross rate is the pure premium and the loading per exposure unit and the gross premium is the premium charged to the insurance applicant, and is equal to the gross rate multiplied by the number of exposure units to be insured.

The ratio of the loading charge over the gross rate is the expense ratio.

Pure Premium = Total Amount of Losses Incurred per year / Number of Exposure Units

Example: An average loss of Rs. 10 million per year per 10,000 automobiles yields the following pure premium:
Pure Premium = Rs. 10,000,000 / 10,000 = Rs. 1000 per Automobile per Year

Gross Rate = Pure Premium + Loading

The loading charge consists of the following aspects:

1. Commissions and other acquisition expenses
2. Premium taxes
3. General administrative expenses
4. Contingency allowances
5. Profit

Loading charges are often expressed as a proportion of premiums, since they increase proportionately with the premium, especially commissions and premium taxes. Hence, the loading charge is often referred to as an expense ratio. Therefore, the gross rate is expressed as a percentage increase over the pure premium:

$$\text{Gross Rate} = \frac{\text{Pure Premium}}{1 - \text{Expense Ratio}}$$

Example: If the Pure Premium is ?700 and the expense ratio is 30%, then:
Gross Rate = Rs. 700 / (1 - 0.3) = Rs. 700/0.7 = Rs. 1000

Gross Premium = Gross Rate x Number of Exposure Units
Expense Ratio = Load / Gross Rate

Other business objectives in setting premiums are:

1. Simplicity in the rate structure, so that it can be more easily understood by the customer, and sold by the agent;
2. Responsiveness to changing conditions and to actual losses and expenses; and
3. Encouraging practices among the insured that will minimize losses.

The main regulatory objective is to protect the customer. A corollary of this is that the insurer must maintain solvency in order to pay claims. Thus, the 3 main regulatory requirements regarding rates are that:

1. Rates are to be fair compared to the risk revelation;
2. Premiums must be adequate to maintain insurer's solvency;
3. Premium rates are not to be biased-the same rates should be charged for all members of an underwriting class with a similar risk profile/exposure.

Although competition would compel businesses to meet these objectives anyway, the states want to regulate the industry enough so that fewer insurers would go bankrupt, since many customers depend on insurance companies to avoid financial calamity. The main problem that many insurers face in setting fair and adequate premiums is that actual losses and expenses are not known when the premium is collected, since the premium pays for insurance coverage in the immediate future. Only after the premium period has elapsed, will the insurer know what its true costs are. Larger insurance companies have actuarial departments that maintain their own databases to estimate frequency and the monitory amount of losses for each underwriting class, but

smaller companies rely on advisory organizations or actuarial consulting firms for loss information.

Some other factors that influence the process of ratemaking include:

1. **Management Expenses:** As mentioned earlier, these expenses are that an insurer will have to incur as he runs the business and include salaries, travel and accommodation, office expenses etc.
2. **Commissions:** This is particularly relevant in the corporate insurance market which globally tends to use professional brokers as distributional channels. As insurance products are not customized, hence requires tailoring and customization. Hence, commissions can range up to 17.5 % as of now in India.
3. **Claims expenses:** In addition to paying out claims, the claims department has some expenses in handling of claims that include use of expert witness, qualified surveyors etc.
4. **No Claims Bonus / Malus:** In motor insurance covers, there is recognized scale of discounts for risks having no claims - being rewarded as the 'No claims Bonus'. This is used in many countries to encourage the insured to drive carefully and if there is a small claim, to consider treating that as "self insured" rather than jeopardizing his no claim bonus, which can be substantial after 4 years of claims free driving. As per the Indian practice, with the stipulated 'Sun Set Clause' when the insurer settles a claim, the insured losses all previously accumulated No Claim Bonus. However, he can again continue to earn no claim bonus for claims free years at subsequent renewals.
5. **Loading / Malus:** There is also a reverse scenario where insurers load the premiums as per a published schedule when the claims experience is bad. Such loading of premium when the claims experience is poor is known as Loading / Malus. Conditions when such loadings are done and the amount of loading are disclosed in advance. In many countries, certain caps are imposed on the loading. Indian Motor Insurance, for instance, caps some loadings at 100% and some types of loadings at 200%.
6. **Trends:** The insurer needs to collate the historical information relating to losses / claims and exposures. However, it is critical that notice is taken of trends - past, present, and future that will affect the assumptions coming from these statistics. This should be done in a structural format and there are a number of areas that need to be considered by the portfolio underwriters. Some of these indicators or trends can be:
1. **Inflation:** in certain classes, the claims costs and exposures will not be consistent as regards inflationary impact. Example hotels may be rated on the number of bedrooms as regards the Public Liability Risk - rejected claims experience should take into account inflationary changes.
2. **Political environment:** Changes in the political landscape can change a country or a part of the country from a high hazard (crime risks) to a low hazard over a relatively short period of time and vice versa. Moreover, issues such as terrorism have significantly increased over the past 20 years.
3. **Technology:** Over the last 3 decades, technology has vastly improves the safety standards in many industries, by reducing manual interventions. For examples. Printing industry has introduced computerized presses, and just-in-time strategy, improving fire risks safety is some improvements.
4. **Legal changes:** Changes in the legal environment, litigation costs can change significantly the claims costs and payouts.
5. **Attractiveness:** Items such as mobile phones, Laptops are attractive in the first year but with the falling prices and greater availability move them into commodity areas and relatively unattractive mode in comparison.
6. **Miscellaneous:** These include climatic changes, global warming and their likelihood of impact on flood risks etc.

Finally while summing up:

Pricing or the appropriate Rate Fixing is very significant to the success of any insurance venture. Underwriting profits needs to be the consistent objective at this Corona affected backdrop of the Indian Insurance Market. The basic pricing premiums in: claims out -leads to pure premium. Pure premium needs adjustment for all the working expenses and normal outgoings of any insurer. Technical rate and book rate are critical for long term underwriting profits. Operational premium issues include rating, catastrophe loading and commercial discounting, but when survival is the focus - Insurers can never be ignorant about this critical need of the underwriting prudence and simply now drastically depend on their underwriters' acumen.

Reference:

Different contemporary discussions & information as collected and collated from various text materials available on-line & in hard copies. ❑

CHILD INSURANCE : A LEGACY TO LEAVE BEHIND

Children are always a bundle of joy. Right from the time they enter your life, all grown up and independent your children are your pride and bliss. Every responsible parent looks for the best of everything for the upliftment of their children. They can go that extra mile to see to it their wards become a Success.

Why should you save for your children?

If you want to nurture your infant, pay for his /her school, college fees you need to spend money. If you want your child to have better and brighter future and career, you need to devise a financial plan for your child's future. Life Insurance stands out to be a better alternative.

The biggest financial worry most Indian parents face about mitigating the overwhelming and ever-increasing cost of education. According to a survey conducted by national sample survey office, the cost of general education has shot up by staggering 175% between 2008 and 2014. At the same time, the cost of professional and technical education has risen by 96% taking this account, it has become critical for parents to plan for their children education.

Question is that how do you plan? for your child's future. There are many options to fulfill the child's need for example investment in equity, bank fixed deposit, mutual funds, but all of them have their own pros and cons. While your investment might yield you a considerable corpus to provide for your child's future expenses. What would happen if you face pre-mature death. How would you secure your child's future then?

About the author

Vijay H Kakhandki

He has worked with leading Insurance Companies including PNB Metlife, Reliance, Bajaj Allianz Life, Max-Life, in multiple capacities.

Currently, he is associated with MABFSI since June'16 as Faculty with Life Insurance vertical.

A child insurance plan comes into play in these situations. The plan provides an avenue of investment for child's future and guarantees the promised corpus even if parents dies. Child insurance plans come with the dual benefit of insurance and investment. Buying a child plan with interim or terminal bonus, as per the need, can help you plan your child's future with security. Some of the plans offer reversionary bonus that is compounded every year, which can help in getting a bigger corpus.

On the other hand, a child insurance plan offers a lump-sum payment on the death of the policyholder, but the policy does not end. All future premiums are waived off and the insurance company continues investing this money on behalf of the policyholder. The child gets the money at specified intervals as planned under the policy. In this way, the parent ensures that his child's needs are taken care of even if he is not around. Investing in a child insurance plan will entitle you to tax deductions for the premiums paid as per Sec 80C of the Income Tax Act, 1961.

As far as the right time to buy a child plan comes into mindtime is when you buy child plan is an important factor for the policy to be effective in terms of premium paid and the returns. Just like any investment to grow substantially, child plans taken for a longer duration pay better whether traditional or ULIP. Since the maturity date of these plans is fixed, it is better to buy these when the child is still young. This gives ample time for the funds to grow.

Buying a plan early in the child's s life also makes premiums for the plan manageable and affordable for a decided upon corpus. Premiums for generating the same return rise with every year delayed. With that in mind, if the child is already in teens, child plans may not be very effective means. It is better to go in for other investment options along with a pure protection plan.

According to the survey done on parents who have purchased insurance for their children, it has been found that these parents become relieved as their burden on education and marriage cost minimizes. And when the maturity period ends, their child can use this money wisely. So, it's your turn now to give your best just like your parents had done for you to your child's dreams of an ideal career, dream wedding, capital for business and so many other specialized needs that children have from time to time.

Dear parents,
Its time to remember, one thing about time, that is time runs very very fast. We will not even know, when our children grew up, and in dire need of money for marriage, business, education etc. etc.

I remember a statement from SBI chairman," Best time to plant a tree was 20 years before, the next best time is now.".So i am reminding parents specially here that, time to buy a child policy or policies right now and now only.

"You don't buy life insurance because you are going to die but because those you love are going to live"
I thank Professor Paramesh for valuable inputs

Foreign direct investment in general insurance slips to Rs. 509 crore in FY20

FDI in the general insurance sector slipped to Rs. 509.07 crore in FY 2019-20 from the previous year, latest data by the General Insurance Council (GIC) showed. In FY2018-19, FDI in the non-life insurance space was recorded at Rs. 516.61 crore. Since the opening up of the insurance market in 2000, the non-life sector attracted a total FDI of Rs. 4,721.68 crore as on March 2020. It was Rs. 4,212.61 crore at the end of March 2019. It is to be noted that FDI limit in the insurance sector has been hiked to 49% from earlier level of 26%. New India Assurance and GIC Re were listed on stock exchanges while ICICI Lombard from the private sector went public in 2017.

BIMTECH
BIRLA INSTITUTE
OF MANAGEMENT TECHNOLOGY

2nd BIMTECH Leadership series Talks by Mr. Bhargav Das Gupta, MD, and CEO of ICICI Lombard General Insurance Co. Ltd.

As an organization If you believe in digitization, you have to ramp it up or else you miss the bus - India is likely to have K-Shape recovery

- Bhargav Dasgupta

Birla Institute of Management Technology (BIMTECH) held its 2nd session of "Leadership Talks from the Top" on the topic of "Reimagining Insurance Industry Post COVID19" by Mr. Bhargav Das Gupta, visionary MD, and CEO of ICICI Lombard General Insurance Company Ltd, India largest non-life private insurer on 31st October 2020.

Prof.Saloni Sinha, the event anchor welcomed Mr.DasGupta along with other stalwarts from the insurance industry who attended the event namely, Mr. BD Banerjee, former Chairman, The Oriental Insurance Co Ltd, and former Insurance Ombudsman, Mumbai. Mr. Arun Agarwal former Managing Director with MS Cholamandalam General Insurance Co. Ltd and currently on the Board of Kotak Mahindra General Insurance as an Independent Director. Mr. KK Mishra, former chief executive officer of Tata AIG General Insurance Co Ltd and currently on the Board of Navi General Insurance. Mr. Nilesh Sathe Former member-Life insurance at IRDAI. Mr. Sakate Khaitan, Senior Partner-Khaitan Legal Associates, and Member- Board of Governors-BIMTECH graced the event with his presence.

Dr. Harivansh Chaturvedi, Director, BIMTECH delivered the welcome address at the event. He shared the distinguished career journey of Mr. Bhargav Das Gupta with the audience especially his role in setting and shaping up the International Banking Group of ICICI globally which was taught as a case study at Harvard Business School. Mr. Chaturvedi shared the vision of the institute to develop its students as ethical leaders with an entrepreneurial mindset and a global outlook. Heexhorted young students to take a leaf out of the career of Mr. Dasgupta to orient themselves to realise broader vision in days to come.

Mr. Bhargav Das Gupta was introduced on the occasion by Vidisha Singhal,an alumna of 2010-12, batch of BIMTECH and currently working as Assistant Vice President (AVP) - Reinsurance with ICICI Lombard General Insurance Company Ltd. She maintained that under the exemplary leadership of Mr. Dasgupta, the company had been blossoming leaps and bounds - the tipping point being the successful listing of its Initial Public Offering (IPO).

Mr. Bhargav Das Gupta initiated his address by stating that the pandemic was the greatest human tragedy and has affected humanity and economy seriously The current pandemic apart from affecting the health of common people and had significantly affected the economy. The world was debating whether the economy would have a V-shaped sharp recovery, U Shaped time-bound recovery, or L shaped flat recovery. He felt it would be a K-shaped recovery where some sectors of the economy would see a sharp recovery and other sectors would have a slow recovery. According to him, the current pandemic was a" transformational event at civilizational level". The world post-pandemic will witness a change in geopolitics as well as the emergence of a new world order along with technological changes. He being part of the insurance sector was interested in seeing what it did to the insurance industry.

Mr. Dasgupta went further and outlined the various effects the pandemic had on corporate and individual consumers. Firstly, the awareness levels and need for insurance especially for life and health insurance had increased among consumers. Secondly, the expectations of the consumers in the manner they consume insurance were towards receiving insurance in a digitized and contactless manner. Thirdly, Consumers want insurers to act as trusted advisors providing them with useful pieces of advice e.g. on the wellness aspect to prevent sickness. Fourthly, new product constructs were involving with changed expectations of customers like customers seeking OPD (Out Patient) cover, reimbursement of expenses for pharmacy and diagnostic bills apart from the traditional IPD (In-Patient) cover in health insurance. Fifthly, the Indian consumers were willing to share their data with the health insurers provided the insurer provided him appropriate wellness solutions in return. Sixthly, he felt that the demand for retail cyber risk coverage products would increase due to a large workforce working from home and the organizations would want them to take home insurance cover as they carried corporate assets with them while working from home. Lastly, he felt for corporate customers the post covid scenario, had made them look at non-damage Business Interruption covers which were not offered in India. The SME sector could opt for pandemic risk covers in the future. There was a need to build pandemic risk pools to build resilience in this sector.

As far as impact on insurers was concerned he enumerated trends and imperative actions to be pursued by insurers in a post covid world. Firstly, all organizations including insurers needed to be more digitized, connected, and agile due to the emergence of a new work-from-home workforce. Organizations have to transform internal processes to meet the challenges of this new environment. Secondly, digitization did not mean selling policies digitally but encompassed having a digital approach right from sourcing policies to settling claims digitally to survive and grow in this new environment. Thirdly, he felt all customers will not make use of digital channels for buying insurance but a few. As many customers still like the interaction with a Bank/ Broker/Agent who offers them advice before purchase.

The important thing was these channels should also deliver the product using digital processes. A hybrid channel approach of reaching out to customers would work best for insurers. Technologies like IoT (Internet of things), Telematics, and RPA (Robotic Process Automation) were leading to increasing better risk management capabilities for insurers. Lastly, he felt insurers need to be cautious and sensitive in a post covid world. This was time to cut down unnecessary costs and optimize resources.

Mr. Das Gupta closed his address by saying the pandemic was a wake-up call to the entire world not only for the insurance sector. This was a time to move from shareholder capitalism to stakeholder capitalism. Shareholders were important for any organization but good organizations would look at the interests of all stakeholders including consumers, employees, and society at large, and take all positive actions for the society as well apart from only looking at enhancing shareholder wealth in a post covid world.

Thereafter, the floor was opened for the Q & A session with Prof. Dr. Abhijit K. Chattoraj, Chartered Insurer& Professor &Chairperson-PGDM-Insurance Business Management Programme acting as a moderator. The Q & A session had active participations from the audience all over the world putting their questions which were answered by Mr. Dasgupta.

To a pointed query by the moderator as to which role among the various roles assumed by him like a leading banker ,life insurer and finally the general insurer ,he likes the most, Mr Dasgupta candidly maintained that his first love remains banking as this was his first job. "The fact that I stayed with Non -life insurance for close to eleven years is a testimony to my liking about general insurance .All I can say is that it is very fascinating to work with general insurance industry as there is so much to learn. I can remind your students that within the BFSI sector, general insurance offers the engineering graduates in particular, the opportunity to leverage their technological knowledge to a great extent" Quipped Mr. Dasgupta.

"We started preparation way ahead of other companies looking at the Europe experience. Even before the lockdown, we had many things in place and also started equipping our employees digitally. We already had digital platform to source policies. 90 % policies in customised SME segment were issued digitally. We settled all claims on virtual platforms. As an organization If you believe in digitization, you have to ramp it up or else you miss the bus" Elaborated Mr. Dasgupta to an another question on digital preparation posed by Prof.Chattoraj.

The event concluded with a vote of thanks proposed to all involved in the successful conduct of the event by Prof. Pratik Priyadarshi. ❑

RMAI Certificate Course on Risk Management

Join Today

Introduction

RISK MANAGEMENT ASSOCIATION OF INDIA (RMAI) has been pioneering the efforts towards awareness on the subject of Risk, creating academic and research environment to empower the professionals in this highly competitive financial services and allied industry.

Keeping pace with the global challenges and emerging opportunities for Professionals post Covid, RMAI is proud to launch the first-ever ONLINE Certificate Course on Risk Management from India. There never has been a more crucial time to stand-out and be counted as a professional who is able to demonstrate the knowledge and ability to anticipate, respond and adapt to critical issues pertaining to risk.

As Risk Management becomes central to today's business environment across the globe, there is a surge in demand for competent and expert risk management professionals to identify, assess, prioritize and develop a proper risk management framework to minimize the impact on businesses.

Online Certificate Course on Risk Management is designed to expand your knowledge and understanding of managing risks in a technology-enabled modern day dynamic business environment.

Every Professional working in the area of risk management and financial services industry, students pursuing courses in insurance and business management, small business owners interested in insights on Risk Management can be immensely benefitted by this 8 Week 30 hour course.

Realizing the imminent need for industry/organizations to have more employees who possess RISK LITERACY along with few experts, RMAI is committed to providing the right foundation of risk-knowledge and market-insights with global best practices.

This certificate Course is a Joint Certification programme of Risk Management Association of India and Association of Internal Control Practitioners (THE AICP), London, UK. (https://theaicp.org)

Course Modules

Module -1- Introduction to Risk Management

Module -2- Understanding Environment and Stakeholders

Module -3- Risk Strategies and Corporate Governance

Module -4- Risk Management Framework

Module -5- Risk Management Process

Module -6- Emerging Risk

Module -7- Types of risks

Module -8- Models for Estimation of Risk

Module -9- Project and Assessment

Course Details

Course Duration/ Time	30 Hours / 8 Week
Final Exam	After 2 Months
Mode of Delivery	Online. E learning Modules
EARN A CERTIFICATE	Post successful completion of the course, Project and Assessment, you shall EARN A CERTIFICATE in RISK MANAGEMENT jointly awarded by Risk Management Association of India and AICP, London. You can use this Certificate across your Professional network and share with current/ prospective employers

Course Fees	INR 15,000 or USD 350 for international participants
Special Offer for first 200 Registrations:	25% Discount on Course Fees — INR 11,250 Plus Exam Fees Rs.750 – Total Rs.12000 International USD 262.50 Plus Exam Fees US₹20 Total US ₹ 282.50
Special Offer for RMAI Members:	40% Discount on Course Fees for Registration – INR Rs.9000 Plus Exam Fees Rs.750 (9750/-)
Final Exam Fees	INR Rs.750 Examination Fees – Indian Students US ₹ 20 – International Students Final Exam shall be conducted by Remote Invigilation.

Course Methodology

i) Online Course spread over eight week (E Learning Modules)

ii) 8 Modules of three hours each Plus Project

iii) Quiz during each module to check understanding

iv) Query Management Sessions by Experts

v) Individual Project and Guidelines

vi) Course Completion Assessment

vii) Final Exam by Remote Invigilation

More about AICP London

Association of Internal Control Professionals was established in London in 2014 the Institute is a not-for-profit organisation.

AICP is Europe's one of leading Institute for professional excellence in Internal Control, Risk Management, Corporate Governance and Compliance, and an innovator in internal control and risk management in Procurement & Supply Chain Management Operations.

The institute's professional membership currently extends to twenty-one countries and provides access to a wealth of skill building, reinforced through consulting, training, assessments, and certificated courses through eLearning.
Website: https://theaicp.org/

Value-added Benefits

- Complimentary Student Membership of RMAI for One Year you can continuously update your knowledge on the subject of Risk Management and upgrade your skill-set with various initiatives of RMAI during the year
- Complimentary Subscription to Online Insurance or Banking Library from SASHI PUBLICATIONS
- Career Opportunity Section on the Website of RMAI (rmaindia.org) which will have list for all new openings and opportunities in risk management and related fields
- Opportunity for publication of research paper and articles in RMAI Bulletin and other platforms
- Participate in Webinars conducted during the period

Payment Options:

1. You can remit the payment by NEFT in our Bank Account details below
   Bank Details of Association :
   Risk Management Association of India
   Bank of India Account Number: 402110110007820
   Branch: Vivekananda Road Branch
   Type of Account: Savings
   IFSC Code : BKID0004021
   MICR Code: 700013048
2. Companies who want to enroll their employees in bulk can request for a invoice at info@rmaindia.org

In case of any Query about the Course you can contact us

EMail: info@rmaindia.org
Phone: 9073791022/8232083010
Post: Risk Management Association of India,
25/1, Baranashi Ghosh Street,
Kolkata – 700007. India

LEGAL

If declaration is late, claim can be rejected

Happy Steels, a private limited company, had obtained an insurance policy from Export Credit Guarantee Corporation of India (ECGC) to cover risk while exporting goods. Happy Steels had exported goods to Overseas Trading Company of USA, which defaulted in making payment.

So Happy Steels lodged claims under the policy. The insurer, however, found that there had been delays in declaration of the shipments for which the claims were lodged. Declarations for five shipments sent on November 14, 2007, March 1, 2008, March 11, 2008, April 5, 2008, and May 23, 2008, were belatedly given on July 11, 2008, only after the payment for the first shipment was overdue by more than three months.

Even though the sixth shipment was sent on July 2,2008, it was not included along with the other declarations given on July 11, 2008, but was given on October 15, 2008 after a delay of over two months. Despite being warned, Happy Steels failed to furnish declaration for 15 subsequent shipments. The insurer pointed out that the policy conditions in respect of timely declaration of shipments had been violated, and rejected all the claims. The insurer also pointed out that this delay had needlessly put it to additional liability as it had to pay the claims of other Indian exporters who could not be alerted about the defaulting Overseas Trading Co.

Happy Steels filed a complaint against the Union of India and ECGC to challenge the repudiation of its claims. It was contested by reiterating the same reasons given in the repudiation letter. The Punjab State Commission upheld the defence of the insurer and dismissed the complaint.

Happy Steels carried the matter in appeal before the National Commission claiming that the loss was covered under the policy. Bharat Sangal, senior counsel appearing on behalf of ECGC, argued that the loss would be covered provided the declaration of the shipment was given on time. It pointed out that the policy required the insured to furnish a declaration of all the shipments made during a particular month during the subsequent month. Even if no shipment was made, that too would have to be submitted as a 'nil' declaration. Additionally, the policy also required that a statement regarding payments overdue by more than a month must be furnished by the end of the next month. The policy stipulated that the submission of these declarations was mandatory, and no claim would be payable if there was a lapse in making the declarations.

The National Commission agreed with the arguments advanced by senior advocate Bharat Sangal, and concluded that the claim had been rightly repudiated as the insurer was absolved of all liability in case of default in submitting the declaration mandated under the policy. The Commission also observed that the insurer could waive its right to enforce strict compliance regarding the declaration, but this was irrelevant as the insurer was well within its right to insist on strict compliance of the requirements under the policy.

Accordingly, by its order of October 13, 2020, delivered by Justice V. K. Jain, the decision of the State Commission dismissing the complaint was upheld.

Insurance co told to pay Rs 63 lakh to kin of 2 farmers killed in road mishap

A Motor Accident Claims Tribunal (MACT) has directed a truck owner and an insurance firm to pay compensation of Rs 30 lakh to the wife and son of a farmer and Rs 33 lakh to the mother of another farmer, both of whom had lost their lives in a 2014 road mishap.

In the fateful incident, the farmers were in a car on the Beed-Ahmednagar highway at 10 pm when a truck hit their

vehicle in a head-on collision, killing all four passengers in it. Both farmers died on the spot. The truck driver fled the scene.

The insurance company had denied the claims for compensation and said that the negligence was not on the part of the truck driver, but on the part of the car driver.

A police inspector who had lodged the FIR in the case deposed before the Tribunal and concluded his evidence stating that the accident was caused due to negligence of the truck driver. He also told the Tribunal that the truck driver had fled leaving the dead and injured at the spot without medical aid. Noting this conduct of the driver immediately after the accident, the Tribunal said that if he had been innocent, he would not have done so. It concluded that the mishap took place due to the negligence of the truck driver.

Tribunal member HB Hedaoo while calculating the compensation for the farmers said that one must put himself in the position of the Indian farmer as only the wearer knows where the shoe pinches. The compensation in matters of death of farmers needs to be decided with some sensitivity, if not with emotions, with a good blend of law, he said.

Calculating the compensation on the basis of the earnings from produce from the farmers' land and the crops they grew, the tribunal said it would be an unjust and inappropriate approach to calculate compensation only on a notional income of the labour the farmer was rendering on his own farm and ignore what he was earning from his field property. Further it stated that it is painful and disturbing that as compared to the case of death of a middleman or trader in farm production, the compensation would have been calculated on tax returns or statements and thus a person in a better position economically and socially would get better compensation.

Company, too, can file consumer complaint

Aerostar Helmets, a private limited company, had booked an apartment in a complex being constructed by Adani M2K Project, a limited liability partnership firm. An agreement was executed on August 31, 2013, by which Adani agreed to sell flat no. G-1502 for Rs 2,34,24,181, which included Rs 12 lakh towards preferential location charge for a flat on the 15th floor.

The agreement stated that possession would be given by September 1, 2017. Even though the entire amount was paid, construction was completed only up to the 10th floor. On October 6, 2017, the builder informed Aerostar that the building would not have a 15th floor, and offered to allot another flat. This offer was not accepted because the flat on the 15th floor was specifically chosen by paying a preferential location charge. The company sought a refund along with 21 per cent interest. The builder was willing to give a refund but refused to pay any interest. So, Aerostar filed a complaint before the National Commission.

Aerostar argued that it was entitled to a higher rate of interest to compensate for the escalation in the price of the flat, as observed by the Supreme Court in Ghaziabad Development Authority vs Balbir Singh. It was also pointed out that the agreement stipulated that 18 per cent interest would be payable by the purchaser to the builder in case of delay in payment, so the minimum interest for default by the builder must correspond to the same rate of 18 per cent per annum.

The builder contested the case, questioning the maintainability of the complaint by a company under the Consumer Protection Act. On merits, the builder relied on the booking application and the agreement in which it was mentioned that if possession could not be given for any reason, an alternative flat could be allotted, or the entire amount would be refunded without damages, interest or compensation. The builder pointed out that the agreement also provided for a grace period of six months, and that an alternative apartment was offered before the expiry of this period, so there was no deficiency in service.

The National Commission observed that a company would also be a consumer in respect of goods or services purchased for its own use and not for trading or profit generation. So, the complaint was held to be maintainable. It also observed that a one-sided clause incorporated by the builder in the agreement cannot be invoked to compel a flat purchaser to accept alternative accommodation. It held that Aerostar was entitled to a refund. Regarding the claim for interest, the National Commission observed that even though the agreement provided that interest was not payable, it could still be claimed as the builder was enjoying the use of the flat purchaser's money. Considering the current interest rate, the Commission held that 8 per cent interest would be reasonable.

Accordingly, by its order of November 18, 2020, delivered by the Bench of Prem Narain and C Viswanath, the National Commission allowed the complaint and ordered the builder to refund the entire amount of Rs. 2,34,24,181 along with simple interest of 8 per cent per annum. Additionally, an amount of Rs. 50,000 was also awarded as litigation cost. A period of 45 days was given for compliance. ❑

IRDAI Circular

Guidelines for Practical Training for Surveyors and Loss Assessors

IRDA/SUR/GDL/MISC/288/12/2020

Date: 02-12-2020

I. Preliminary

These guidelines set out the detailed procedure for practical training for obtaining fresh / renewal licence to act as a surveyor and loss assessor.

These guidelines are being issued in terms of Sec.14 of IRDAI Act, 1999 and in terms of Regulation 28 of Insurance Regulatory and Development Authority of India (Insurance Surveyors and Loss Assessors) Regulations, 2015 and amendments thereof.

II. Fresh Applicants (applying for Surveyor and Loss Assessor Licence for the first time)

1. The Applicants shall complete the prescribed practical training for obtaining fresh License to act as Insurance Surveyor and Loss Assessor after having fulfilled the following:
   a. The applicant must comply with the qualification criteria set out in the schedule 1 of the Regulations, 2020.
   b. Shall enroll with IRDAI for the written examination with Insurance Institute of India and qualify in the examination.
   c. The applicant should enroll himself / herself as Student Member with IIISLA.
2. The Student Member enrolled with the Authority shall pass the examination and complete training within a period of three years from the date of enrolment.
3. The applicant shall then undergo practical training either
   a) for 2 months with Insurance Institute of India / National Insurance Academy / any other institution approved by the IRDAI from time to time

   (Or)

   b) through internship for 6 months with any Insurance Surveyor and Loss assessor who has at least 8 years' experience in the concerned department.
4. The approved Institute / insurance Surveyor and Loss Assessor shall give "Training evaluation cum completion certificate" to the successful candidates.
5. The student member shall submit the "Training evaluation cum completion certificate" to IRDAI for issue of licence.

III. Insurance Surveyor and Loss Assessor seeking licence in additional departments:

1. The Applicants shall complete the prescribed practical training for obtaining license in each of the additional departments, after having fulfilled the following:
   a. The applicant must comply with the qualification criteria set out in the schedule 1 of the Regulations, 2020.
   b. Shall enroll with IRDAI for the written examination with Insurance Institute of India and qualify in the examination
2. The applicant shall then undergo practical training either,
   (a) for 2 weeks with Insurance Institute of India / National Insurance Academy / any other institution approved by the Authority from time to time

   (Or)

(b) through internship for 8 weeks for each department with any Insurance Surveyor and Loss Assessor who has at least 8 years' experience in the concerned department.

3. The approved Institute / Insurance Surveyor and Loss Assessor shall give training evaluation cum completion certificate to the successful candidates.

4. The applicant shall submit the training evaluation cum completion certificate to IRDAI for issuance of modified license

IV. This is issued with the approval of Competent Authority

(Suresh Mathur)
Executive Director

Guidelines for grant of fresh licence / renewal of license to act as Insurance Surveyor and Loss Assessor

IRDA/SUR/GDL/MISC/287/12/2020

Date:02-12-2020

I. Preliminary:

1. These guidelines set out the procedure for obtaining fresh license or renewal of licence to act as a surveyor and loss assessor.

2. The guidelines are being issued under Sec.14 of the IRDAI Act,1999 and in terms of Regulations 28 of Insurance Regulatory and Development Authority of India (Insurance Surveyors and Loss Assessors) Regulations, 2015.

II. Licensing Procedure:

1. Registration: the applicants are required to register with the IRDAI portal viz. www.irda.bap.org.in and obtain a user ID. Applicants are requested to ensure that correct E-Mail ID and mobile number are provided.

2. Submission of application: The applicants shall submit the prescribed forms available in the IRDAI Portal duly filled in all aspects along with all necessary documents through the portal. While uploading the documents, applicants shall ensure that the same are legible. Illegible documents shall be rejected.

   The applicant shall upload the documents online but shall maintain the original physical copies of all the relevant certificates with him throughout the period of validity of licence issued by Authority and shall produce the same whenever sought by Authority.

   All documents shall be self-attested.

3. Licence fee: The payment of applicable fee shall be made using the online payment providers available in the portal.

   i) BillDesk and PayGov are the two different online payment service providers who provide the following payment options to the applicants:

   a. BillDesk:
      i. Net Banking

   b. PayGov
      i. Net Banking
      ii. Credit Card
      iii. Debit Card
      iv. UPI
      v. Wallet

   ii) The fee paid is non-refundable.

III. Fit and Proper Criteria:

"Fit and Proper" criteria refers to the criteria for determining the suitability of an Applicant, whether individual or corporate including Directors or Partners, and their employees (in case of Corporates) for grant of fresh license / renewal of license are persons of integrity, having appropriate skills and experience. For the purpose of determining whether an applicant / surveyor is a 'Fit and Proper Person', the following shall be considered-

a) Financial integrity;

b) Absence of convictions or civil liabilities involving moral turpitude;

c) Appropriate competence, experience and qualification;

d) Good reputation and character;

e) Efficiency and honesty;

f) Absence of any disqualification to act as 'intermediary or insurance intermediary' as stipulated in Section 42D of the Insurance Act, 1938

The applicants shall furnish a declaration cum undertaking in the prescribed form IRDAI AF 20 to determine the 'fit and proper' status.

IV. Issuance of Licence

On completion of the procedure stated in II and III above, the licence will be issued and mailed to the registered E-Mail ID.

V. Issuance of Licence

The existing forms available on the IRDAI Portal www.irda.bap.org.in, as are relevant, shall continue to be utilized till such time the revised forms are implemented on the Portal. Applicant shall submit FORM IRDAI 20 AF (Fit and Proper Criteria) along with other relevant application as below:

a) FORM IRDAI 1 AF (Fresh Individual)

b) FORM IRDAI 3 AF (Fresh Corporate)

c) FORM IRDAI 5 AF (Renewal Individual)

d) FORM IRDAI 6 AF (Renewal Corporate)

e) FORM IRDAI 13 (Enrollment)

f) FORM IRDAI 17 AF (Modification Individual)

g) FORM IRDAI 18 AF (Modification Corporate)

These guidelines shall come into force with immediate effect.

(Suresh Mathur)
Executive Director

Mismatch in GDP flash Figures and Segment wise GDP figures total

IRDAI/NL/CIR/MISC/292/12/20-21

Date:02-12-2020

It is observed that there is mismatch in GDP flash figures and Segment wise GDP figures total for some insurers.

Since data is maintained and collected in electronic format, there should not be any difference even small.

Hence, insurers are advised to examine the reason(s) of differences (even small), if any, between submitted GDP flash figures and segment wise GDP figures total and communicate such reason(s) to us while submitting monthly business figures.

(Yegnapriya Bharath)
CGM (Non-Life)

Guidelines on Insurance claims of victims of Cyclone Nivar (Nov,2020) in the calamity affected areas.

IRDA/NL/CIR/MISC/290/12/2020

Date:02-12-2020

1. As you are aware, cyclone Nivar (Nov,2020) has caused loss to property in some parts of the country. The General Insurers may have issued policies for protection of lives and property located in the affected areas. There is an urgent need for the insurance industry to take immediate steps to mitigate the hardships of the affected insured population by ensuring immediate registration and settlement of eligible claims.
2. You are advised to initiate immediate steps for quick registration and disposal of claims on the following lines:-
   a. Please nominate a senior officer at the company level who would act as a Nodal Officer for the affected states. The Nodal Officer would be coordinating the receipt, processing, and settlement of all eligible claims. The Nodal officer should contact the designated officers of the State Govt. immediately and be in regular contact thereafter.
   b. It needs to be ensured that all claims are surveyed immediately and claim payments/on account payments are disbursed at the earliest and in any case not exceeding the stipulated time-line.
   c. Adequate number of surveyors may be engaged immediately as required.
   d. You are also requested to launch extensive awareness campaign duly highlighting the measures taken by you.
   e. In view of Corona Virus (Covid-19) pandemic, the Insurers shall encourage the policyholders to use electronic communication wherever possible for correspondence while intimating the claim and filing all the relevant documents. Efforts shall be made to ensure that digital processes are resorted to the extent possible for assessment of claims.
3. We request you to take urgent steps for expeditious settlement of claims in the cyclone hit areas and submit details of the same as advised above.

Yegnapriya Bharath
Chief General Manager (Non-Life)

DEPOSIT INSURANCE AND CREDIT GUARANTEE CORPORATION - INSURED DEPOSITS

(Number in Lakh; Amount in ₹ Crore)

Year	Number of fully protected accounts	Total number of accounts	Total amount of insured deposits	Total amount of assessable deposits
1	2	3	4	5
1982	1580	1600	31774	42360
1983	1790	1820	37746	50797
1984	2000	2030	46340	61880
1985	2150	2240	56211	76517
1986	2320	2360	62878	86214
1987	2520	2570	75511	103044
1988	2710	2780	90192	126864
1989	3060	3140	101682	140746
1990	2980	3090	109316	156892
1991	3170	3290	127925	186307
1992	3400	3540	164527	244375
1993	3500	3530	168405	249034
1994	4960	4990	266747	364058
1995	4820	4870	295575	392072
1996	4270	4350	337671	450674
1997	3710	4110	370531	492280
1998	4540	4640	439609	609962
1999	4300	4420	498558	704068
2000	4320	4460	572434	806260
2001	4640	4820	674051	968752
2002	5780	6000	828885	1213163
2003	5190	5440	870940	1318268
2004	6200	6500	991365	1619815
2005	5060	5370	1052988	1790919
2006	6830	7170	1372597	2344351
2007	9620	10390	1805081	2984800
2008	12040	13490	1908951	3398565
2009	12670	14240	1682397	4587967
2010	9770	10520	1735800	4952427
2011	9960	10730	1904300	5767400
2012	13930	14820	2158400	6621100
2013	12670	13700	2379200	7616600
2014	13450	14560	2606800	8475200
2015	15530	16820	2826400	9405300
2016	17380	18850	3050900	10353100
2017	17750	19410	3275300	11202000
2018	20000	21740	3370000	12005100
2019	21610 (23100)	23500	3696100 (6871500)	13488900

Note : See Notes on Tables.

Source : Deposit Insurance and Credit Guarantee Corporation.

Glossary

Insurable Interest
A right or relationship in regard to the subject matter of the insured contract such that the insured can suffer a financial loss from damage, loss or destruction to it. (Bickelhaupt and Magee).

Insurance
An economic device transferring risk from an individual to a company and reducing the uncertainty of risk via pooling.

Insurance Holding Company System
Consists of two or more affiliated persons, one or more of which is an insurer.

Insurance Regulatory Information System (IRIS)
A baseline solvency screening system for the National Association of Insurance Commissioners (NAIC) and state insurance regulators established in the mid-1970s.

Poll

Yes
No
Can't say

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Results of Poll in our November 2020 Issue

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Yes	100
No	00
Can't say	00

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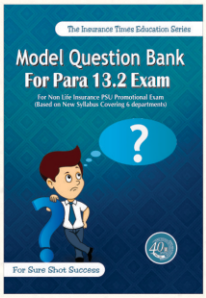

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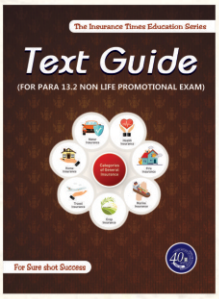

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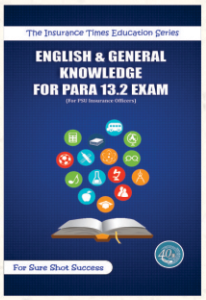

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